

1
M

08370

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

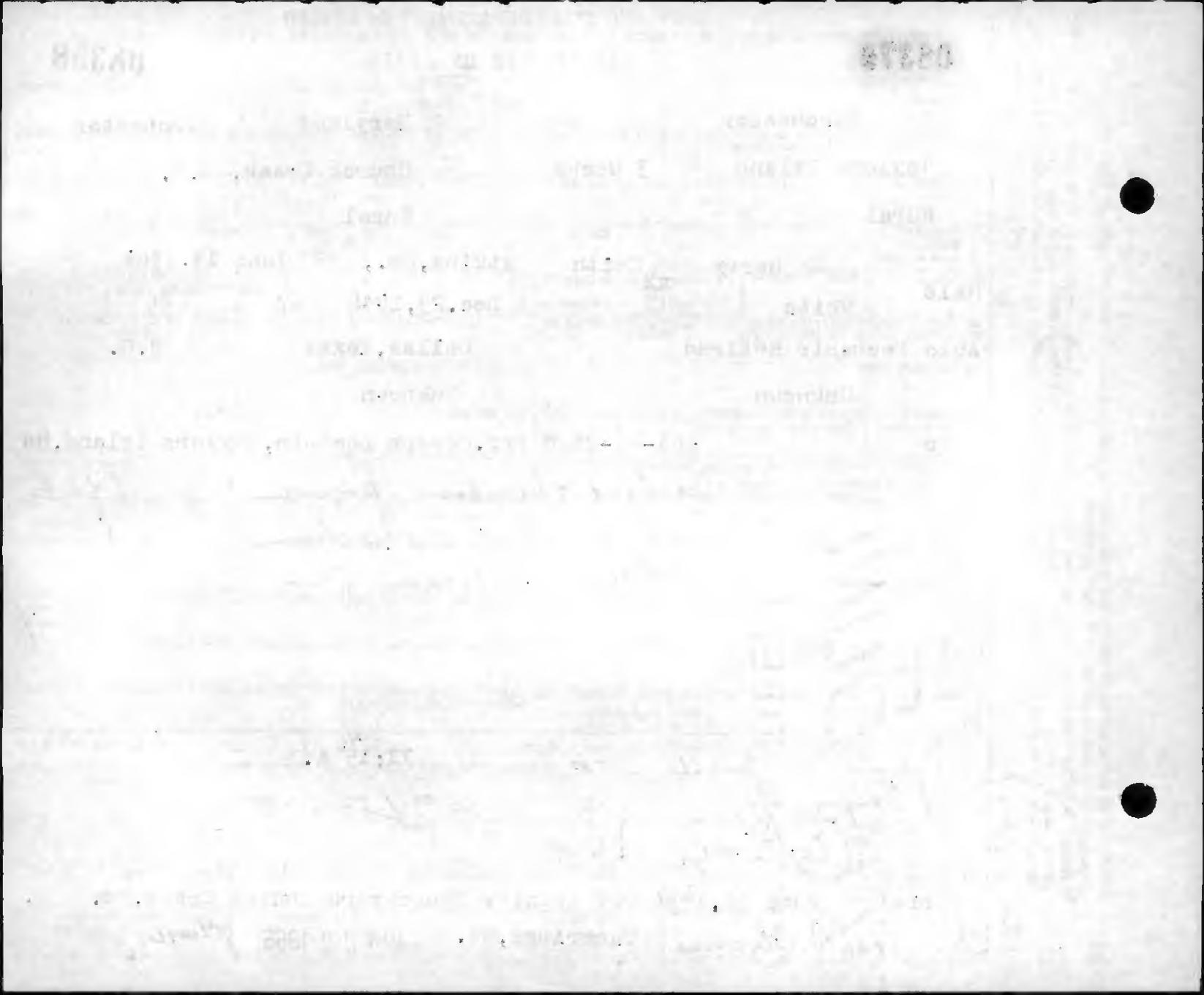
CERTIFICATE OF DEATH

08358

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

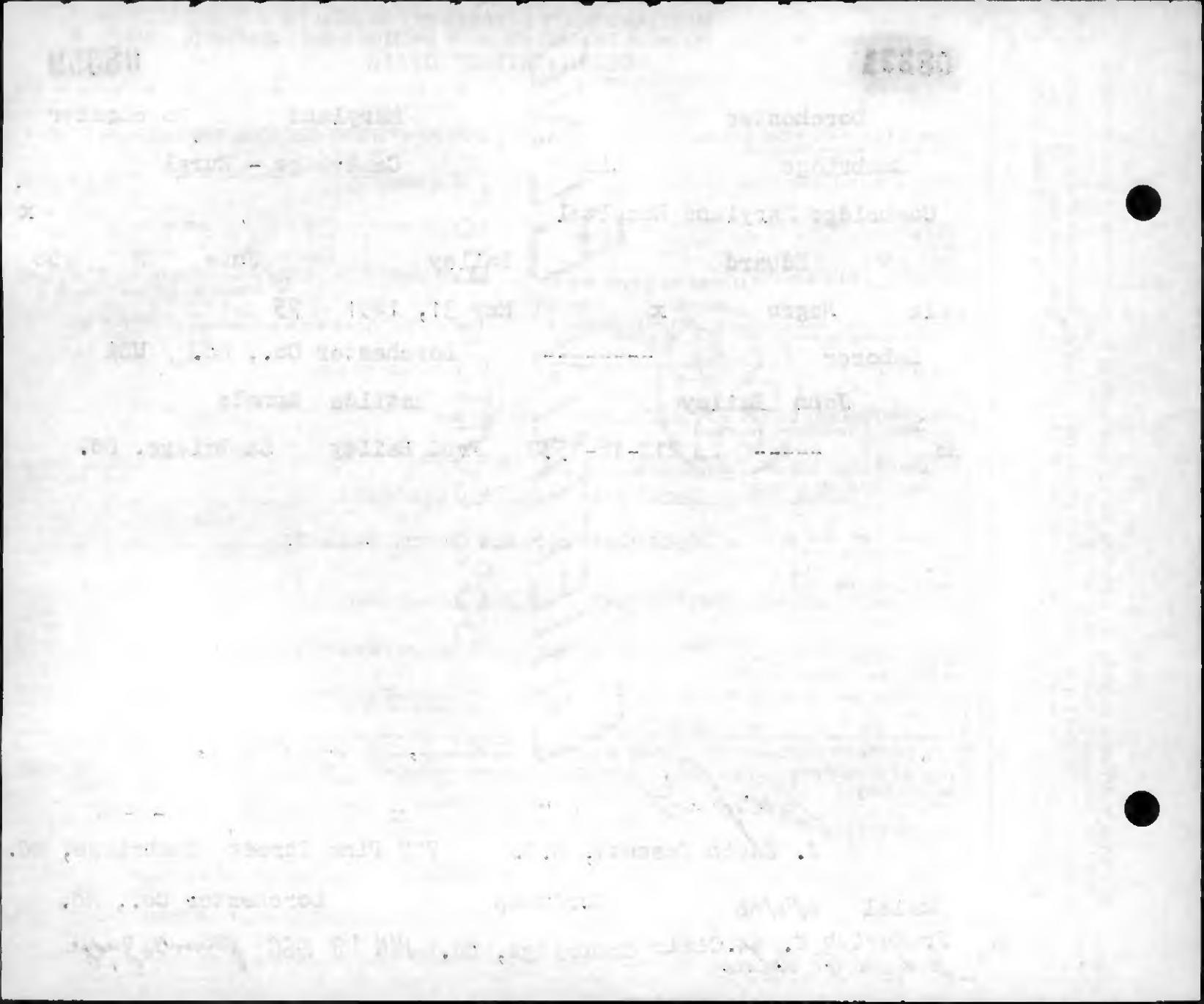
1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Taylors Island		b. COUNTY Dorchester		
c. LENGTH OF STAY IN 1b 3 weeks		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Church Creek, R.D.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rural		d. STREET ADDRESS Rural		
3. NAME OF DECEASED (Type or print) Henry Keith Atkins, Sr.		First Henry	Middle Keith	
4. DATE OF DEATH June 19, 1966	Month 19	Day 19	Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	
8. DATE OF BIRTH Dec. 23, 1898		9. AGE (in years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Dallas, Texas
13. FATHER'S NAME Unknown		14. MOTHER'S MOTHER'S NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 001-03-2628		17. INFORMANT Mrs. Joseph Lambdin, Taylors Island, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address INTERVAL BETWEEN ONSET AND DEATH 6 weeks		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x		<i>Cerebral Thrombosis, priapism</i>		
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b) <i>Cerebral Arteriosclerosis</i>	DUE TO (c) <i>Arteriosclerosis, priapism</i>	?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)				
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>White at work</i>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White Not White at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Jun 10 1966 , and that death occurred at 11:15 A.M. on Jun 19 1966 , to 1966 , that (I) (we) last				
22a. SIGNATURE <i>John J. Thomas</i>		22b. DATE SIGNED 1966		
22c. PHYSICIAN'S NAME (Type) <i>John J. Thomas</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 21, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Old Trinity Churchyard	23d. LOCATION (City, town or county) (State) Church Creek, Md.
24. FUNERAL DIRECTOR <i>James R. Thomas</i>		ADDRESS Cambridge, Md.	25a. REC'D BY REGISTRAR JUN 22 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and/or any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH							
a. COUNTY Dorchester MARYLAND				a. STATE Maryland b. COUNTY Dorchester				First Edward Middle Bailey Last Bailey				Month June Day 2 Year 1966							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge Life				c. LENGTH OF STAY IN 1b Cambridge - Rural				d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
63				6. COLOR OR RACE Negro				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH May 31, 1891				9. AGE (in years last birthday) 75 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md.				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Bailey				14. MOTHER'S MAIDEN NAME Matilda Ennals				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 212-16-1580				17. INFORMANT Fred Bailey Address Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				19. INTERVAL BETWEEN ONSET AND DEATH															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident																			
4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO (b) Arteriosclerotic Heart Disease															
DUE TO (c)																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 1, 1966 to June 2, 1966 that (I) (we) last saw the deceased alive on June 2, 1966 , and that death occurred at M , from the causes and on the date stated above.																22b. DATE SIGNED 6-2-66			
22a. SIGNATURE <i>J. Edwin Fassett</i>				22b. DATE SIGNED 6-2-66				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS 727 Pine Street Cambridge, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6/4/66				23c. NAME OF CEMETERY OR CREMATORIAL Cordtown				23d. LOCATION (City, town or county) (State) Dorchester Co., Md.							
24. FUNERAL DIRECTOR Frederick C. St. Clair				ADDRESS Cambridge, Md.				25a. REC'D BY REGISTRAR JUN 13 1966				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>																			



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08372

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08372

CERTIFICATE OF DEATH

08360

1. PLACE OF DEATH
a. COUNTY

Dorchester MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge

c. LENGTH OF STAY IN 1b

Few hrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Cambridge Maryland

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

August

Boevers

6

13

1966

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

9. AGE (in years
last birthday)86
yrs.10. IF UNDER 1 YEAR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)10b. KIND OF BUSINESS OR
INDUSTRY

Farmer - Ret.

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

Kansas

U.S.A.

13. FATHER'S NAME

Henry Boevers

14. MOTHER'S MAIDEN NAME

Augusta Lombard

Address

Mrs Helen Gale - Vienna, Md.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4341

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO

(c)

HEART
CONGESTIVE FAILUREINTERVAL BETWEEN
ONSET AND DEATH
5 MOS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

Hour a.m.

p.m.

White

Not White

at work

at work

19

at work

100000

200000

100000
200000
300000
400000
500000
600000
700000
800000
900000
1000000
1100000
1200000
1300000
1400000
1500000
1600000
1700000
1800000
1900000
2000000
2100000
2200000
2300000
2400000
2500000
2600000
2700000
2800000
2900000
3000000
3100000
3200000
3300000
3400000
3500000
3600000
3700000
3800000
3900000
4000000
4100000
4200000
4300000
4400000
4500000
4600000
4700000
4800000
4900000
5000000
5100000
5200000
5300000
5400000
5500000
5600000
5700000
5800000
5900000
6000000
6100000
6200000
6300000
6400000
6500000
6600000
6700000
6800000
6900000
7000000
7100000
7200000
7300000
7400000
7500000
7600000
7700000
7800000
7900000
8000000
8100000
8200000
8300000
8400000
8500000
8600000
8700000
8800000
8900000
9000000
9100000
9200000
9300000
9400000
9500000
9600000
9700000
9800000
9900000
10000000

08373
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08373
CERTIFICATE OF DEATH

08361

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Cambridge		09-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital				d. STREET ADDRESS Taylors Island		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Female		First EDITH	Middle RIDGWAY	Last BOILEAU	4. DATE OF DEATH June 12 1966	Month June	Day 12	Year 1966
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1894	9. AGE (In years last birthday) 71 yrs.	10. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Norristown, Penna.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William G. Ridgway		14. MOTHER'S MAIDEN NAME Mary Orbison						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mr. Wallis Boileau, Taylors Island, Md.		Address		
No		---						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage								
331X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the cause (a), stating the underlying cause last.								
(b) Arterio sclerosis, generalized and cerebral								
DUE TO Arterio sclerosis, underlying cause last.								
(c) Generalized and cerebral								
INTERVAL BETWEEN ONSET AND DEATH 30 Hours								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
19								
21. I certify that (I) attended attended the deceased from 1-228, 1966, to 6-12-, 1966, that (I) saw last saw the deceased alive on 6-12- 1966, and that death occurred at 12:30 P.M. from the causes and on the date stated above.								
22a. SIGNATURE Eldridge H. Wolff		22b. DATE SIGNED 6-12-66						
22c. PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M. D.		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/>	M.D. M.D. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF June 15, 1966	23c. NAME OF CEMETERY OR CREMATORIUM West Laurel Hill Cemetery	23d. LOCATION (City, town or county) Philadelphia, Penna.	(State)			
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS		25a. REC'D BY REGISTRAR JUN 15 1966	25b. DIRECTOR'S SIGNATURE John J. LeCompte			

1 M
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any 6-day period is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08374 08363

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
DORCHESTER MARYLAND		MARYLAND DOR.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
CAMBRIDGE		10 MIN EAST NEW MARKET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
CAMBRIDGE HOSPITAL		63	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
ELIZABETH M.	ELIZABETH	M.	DELAHA
4. DATE OF DEATH	Month	Day	Year
JUNE	4	19	66
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
F	W	9/11/03	9. AGE (in years last birthday) 62 yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Housewife		MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME T. W. MERRICK		14. MOTHER'S MAIDEN NAME IDLIA MOWBRAY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
W.M.C. DELAHA			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION			
4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 HRS			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN MACE JR.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 6/17/66		23b. DATE THEREOF 6/17/66	
23c. NAME OF CEMETERY OR CEREMONY Washington		23d. LOCATION (City, town or county) St. Lucie	
24. FUNERAL DIRECTOR John S. Hollingsby, East New Market		25a. REC'D BY REGISTRAR JUN 9 1966	
ADDRESS John S. Hollingsby, East New Market		25b. REGISTRAR'S SIGNATURE Charles Judge	

20120

20120

1
FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY
Dorchester MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cambridge

c. LENGTH OF STAY IN 1b
3 mos

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Eastern Shore State Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE
Md. b. COUNTY
Queen Anne

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chester

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?
YES NO

3. NAME OF DECEASED
First *Ida* Middle *Katherine* Last *Edwards*

4. DATE OF DEATH
Month *6* Day *19* Year *1966*

5. SEX
w

6. COLOR OR RACE
W

7. MARRIED NEVER MARRIED
WIDOWED DIVORCED

8. DATE OF BIRTH
06-19-06

9. AGE (In years last birthday)
60 yrs.

10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months *0* Days *0* Hours *0* Min. *0*

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife

10b. KIND OF BUSINESS OR INDUSTRY
None

11. BIRTHPLACE (State or foreign country)
Virginia

12. CITIZEN OF WHAT COUNTRY
U.S.A.

13. FATHER'S NAME
Blake Edwards

14. MOTHER'S MAIDEN NAME
UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No

16. SOCIAL SECURITY NO.

17. INFORMANT
Records - E.S.S. Hospital

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
(IMMEDIATE CAUSE (a))
1201 DUE TO
Conditions, If any, which gave rise to immediate cause (b), stating the underlying cause last.
(b)
(c)

Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m. 19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

MEDICAL CERTIFICATION

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER
ACTUAL SIGNATURE *Pete W. Rieckert*

M.D. ASSISTANT MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER

22. DATE SIGNED
6-20-66

EXAMINER'S NAME (Type)
Pete W. Rieckert E-New Market

Address (Street, city, town, or county)

23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL

23b. DATE THEREOF
JUNE 22

23c. NAME OF CEMETERY OR CREMATORIUM
STEVENSVILLE

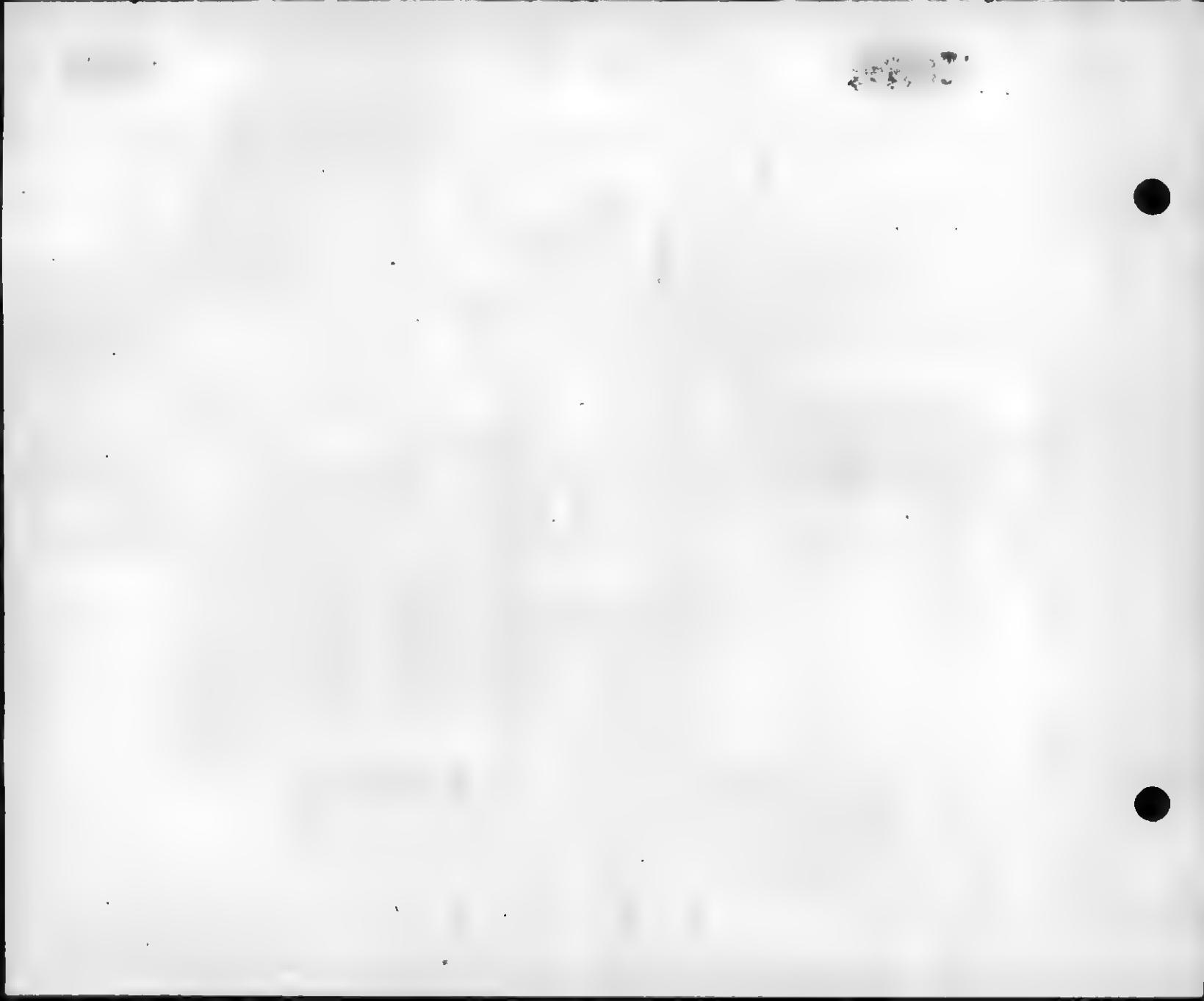
23d. LOCATION (City, town or county) (State)
STEVENSVILLE

24. FUNERAL DIRECTOR
Southern Maryland Funeral Home

25a. REC'D BY REGISTRAR
ADD (1414) 111-1111

25b. REGISTRAR'S SIGNATURE
Charles Judge

VR AISM (5) 1/65



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

08376

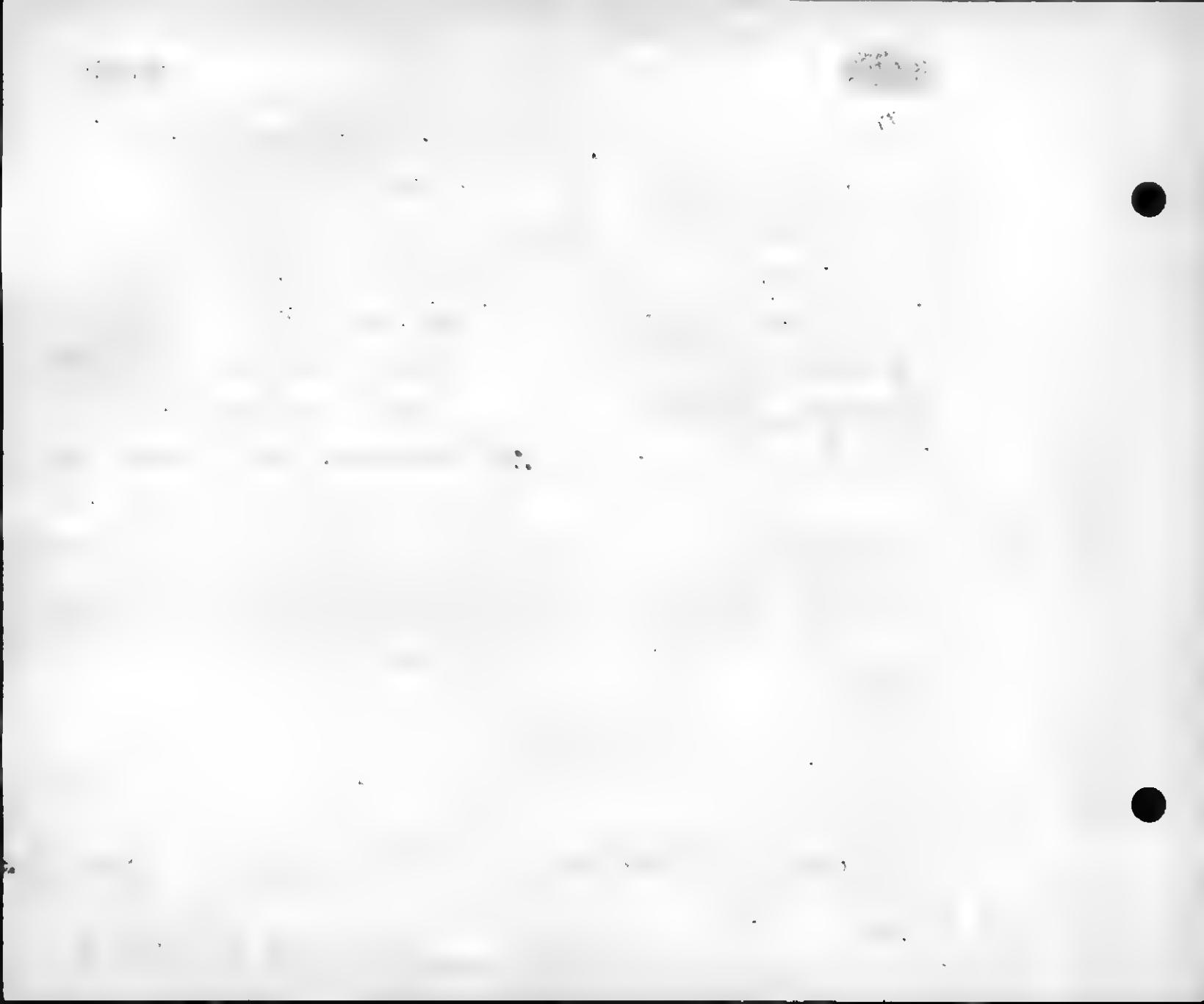
CERTIFICATE OF DEATH

08365

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

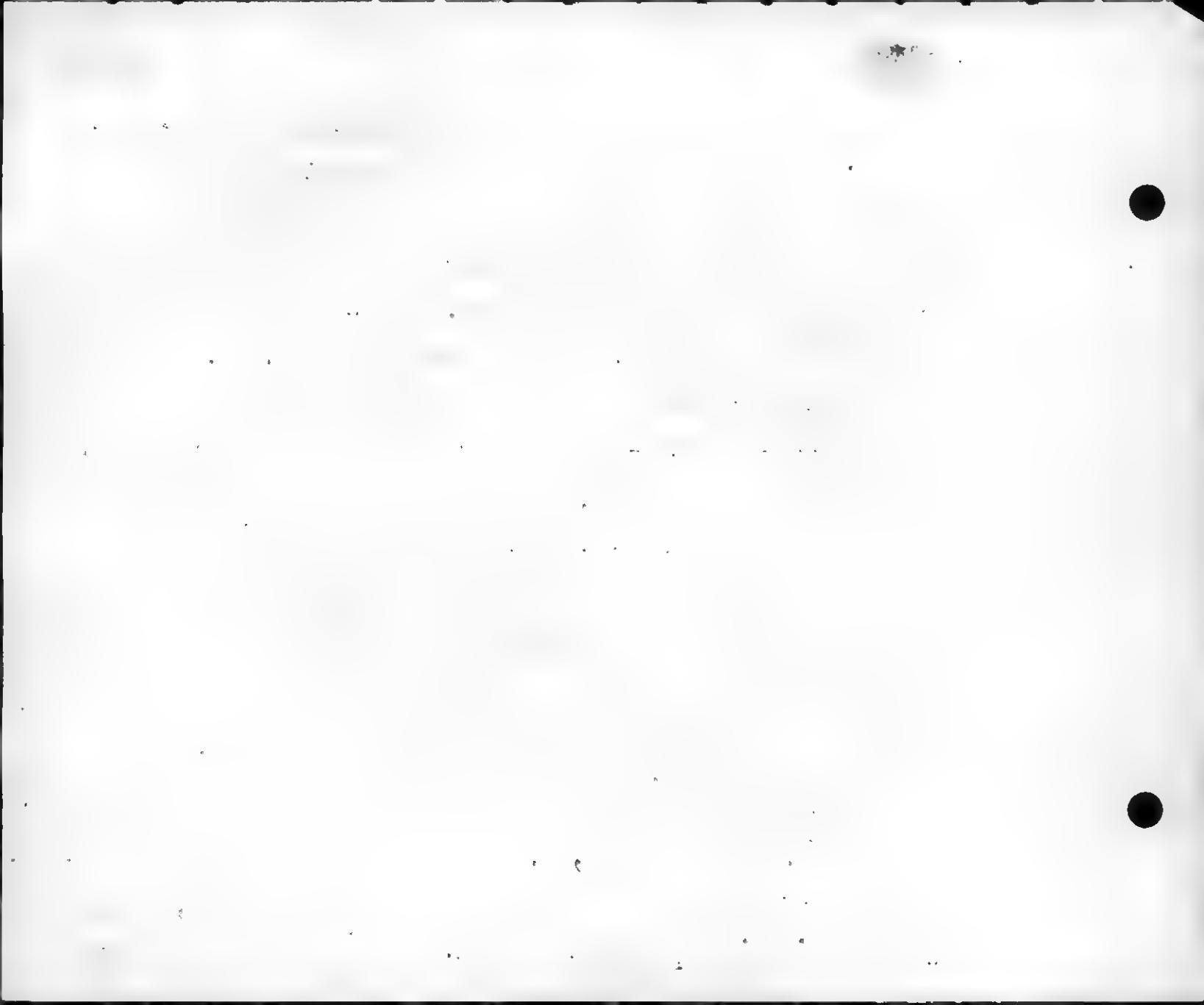
1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge (Rural) Maryland</i>		c. LENGTH OF STAY IN 1b <i>1 month</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Eastern Shore State Hosp.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rock Hall</i>	
3. NAME OF DECEASED (Type or print) <i>Mary</i>		First <i>Anna</i>	Middle <i>Goodman</i>
4. DATE OF DEATH Month <i>June</i>	Day <i>16</i>	Year <i>1966</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>Wh</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-27-72</i>
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>Housewife</i>		10b KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <i>Wesley Pierce</i>		14. MOTHER'S, MARRIED NAME <i>Julia Goodman</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>3</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Records - Eastern Shore State Hosp.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>4-00</i> DUE TO <i>pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>General debilitation</i> DUE TO <i>years</i> (c) <i>Generalized arteriosclerosis</i> DUE TO <i>years</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>10 hrs</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chronic brain syndrome.</i>			
20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>N. A.</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>Hour p.m. 19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Rock Hall</i>
20f. (City or town) <i>Rock Hall</i>		(County) <i>Wicomico</i>	(State) <i>MD</i>
21. I certify that <i>John B. Webster</i> (this hospital) attended the deceased from <i>5-19</i> , 1966, to <i>6-16</i> , 1966, that <i>he</i> (he) lost saw the deceased alive on <i>6-16</i> , 1966, and that death occurred at <i>8:00 A.M.</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>John B. Webster</i>		22b. DATE SIGNED <i>6-16-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>John B. Webster</i>		22d. ADDRESS <i>Eastern Shore State Hosp.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9/18/46</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Wiley Chapel Am</i>		23d. LOCATION (City or Town) <i>Rock Hall Md</i>	
24. FUNERAL DIRECTOR <i>Marvin L. Williams</i>		ADDRESS <i>Charlottesville</i>	25c. REC'D BY REGISTRAR <i>Charles Judge</i>
		DATE <i>JUN 21 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital				d. STREET ADDRESS 911 Maces Lane										
3. NAME OF DECEASED (Type or print)		First Winfield	Middle LeCompte	Last Henson	4. DATE OF DEATH June 4, 1966		Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1906	9. AGE (In years (last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. HOURS	13. MIN.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (County & State, or foreign country) Dorchester Co. Md.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alfred Henson				14. MOTHER'S MAIDEN NAME Emma Henson										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-10-8902		17. INFORMANT Ruth Henson	Address Cambridge, Md.				INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, Cardiac Decompensation-Severe DUE TO Anuria Conditions, If any, which gave rise to Immediate cause (a), stating the (b) Hypertensive Cardiovascular Renal Disease DUE TO underlying cause last. (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus														
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from May 28, 1966 to June 4, 1966 that (I) (we) last saw the deceased alive on June 1, 1966 , and that death occurred at M , from the causes and on the date stated above.														
22a. SIGNATURE <i>J. Edwin Fassett</i>				b. DATE SIGNED 6-4-66										
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.				22d. ADDRESS 727 Pine Street Cambridge, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6/7/66		23c. NAME OF CEMETERY OR CREMATORIAL Bethel		23d. LOCATION (City, town or county) (State) Cambridge, Md.						
24. FUNERAL DIRECTOR Frederick C. St. Clair				ADDRESS Cambridge, Md.										
25a. REC'D BY REGISTRAR JUN 13 1966				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>										



FOR STATE
HEALTH DEPT.

DEATH CERTIFICATE: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

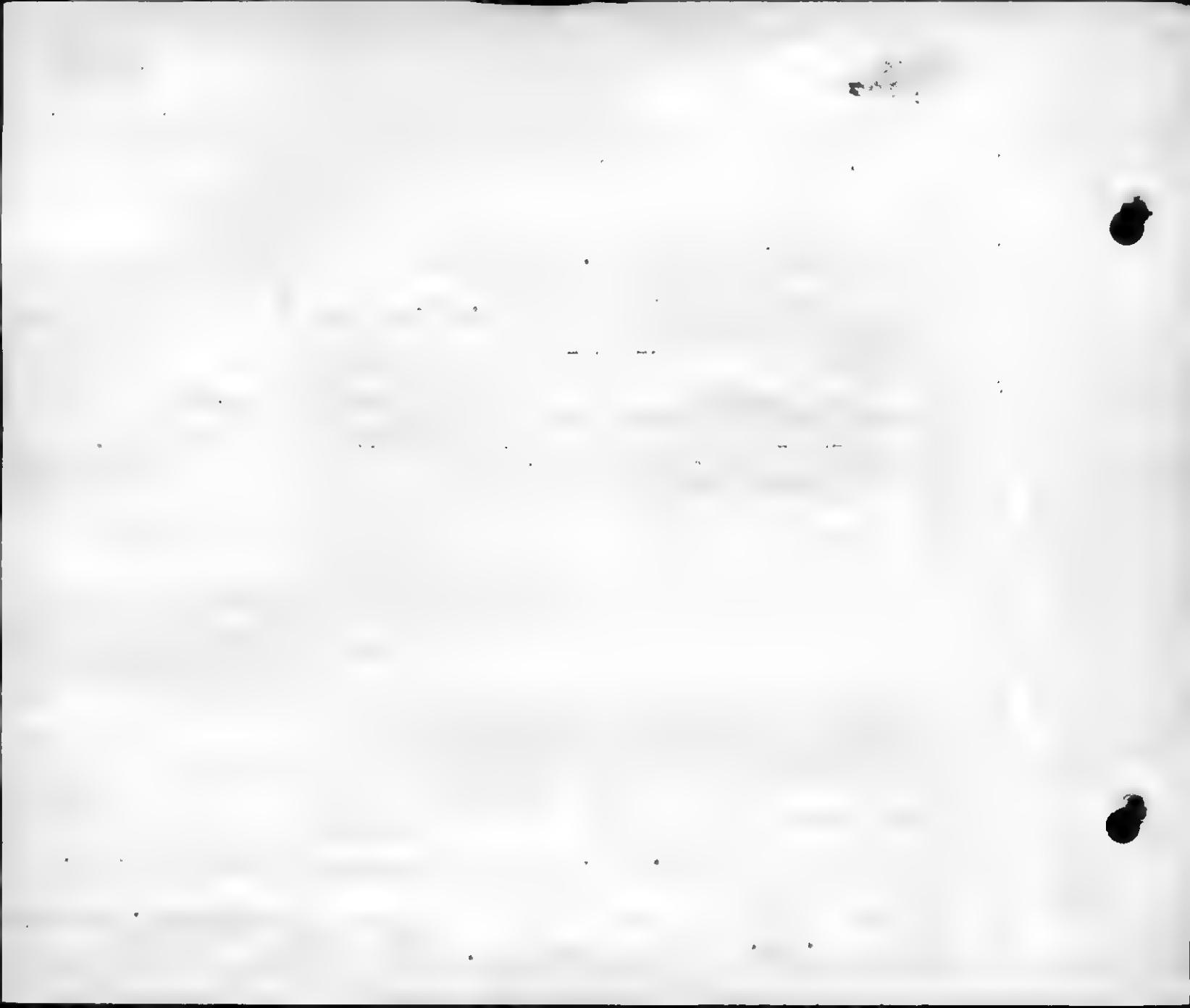
08373

08367

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge		b. COUNTY Dorchester	
c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 500 Dobson Street			
3. NAME OF DECEASED (Type or print) Annie	First E.	Middle Jackson	Last June 1, 1966
4. DATE OF DEATH Feb. 14, 1890	Month 76	Day IF UNDER 1 YEAR	Year IF UNDER 24 HRS.
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1890
9. AGE (In years last birthday) 76	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME John Ennals			
14. MOTHER'S MAIDEN NAME Elizabeth Burroughs			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give name or date of service) -----	
17. INFORMANT Dorothy Jackson		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. } (b)		INTERVAL BETWEEN ONSET AND DEATH, if start -----	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Hour a.m. p.m. 19		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. ACTUAL SIGNATURE <i>John Mace</i>			
EXAMINER'S NAME (Type) John Mace, Jr. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/5/66	
22c. NAME OF CEMETERY OR CREMATORIAL Bethel		22d. LOCATION (City, town, or county) Cambridge, Md.	
23. FUNERAL DIRECTOR Frederick C. St. Clair		ADDRESS Cambridge, Md.	
24a. REC'D. BY REGISTRAR JUN 13 1966		24b. REGISTRAR'S SIGNATURE <i>Charles Judy</i>	

100

VR A15M
5M 1/63



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

08373

CERTIFICATE OF DEATH

08368

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		d. STREET ADDRESS 812 Park Lane	
3. NAME OF DECEASED (Type or print)	First Beatrice	Middle Jackson	4. DATE OF DEATH Month June Day 22 Year 1966
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1897 9. AGE (In years last birthday) 69 yrs
10a. US. OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levi Wilson		14. MOTHER'S MAIDEN NAME Louisa Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 212-18-6091	17. INFORMANT Marva Sampson Address East New Market, Md.
18. CAUSE OF DEATH (Enter only one cause per line of (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Cerebral vascular hemorrhage Hypertension arteriosclerotic H.D. INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. June 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7 June 1966 to 26 June 1966 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at Cambridge , from causes and on the date stated above.			
22a. SIGNATURE <i>J. Edwin Fassett</i>		22b. DATE SIGNED M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.		22d. ADDRESS 227 Pine Street Cambridge, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 6/26/66	23c. NAME OF CEMETERY OR CREMATORIUM Bethel
24. FUNERAL DIRECTOR Frederick C. St. Clair		ADDRESS Cambridge, Md.	25a. LOCATION (City or Town) Cambridge (County) Dor. Md. (State)
			25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

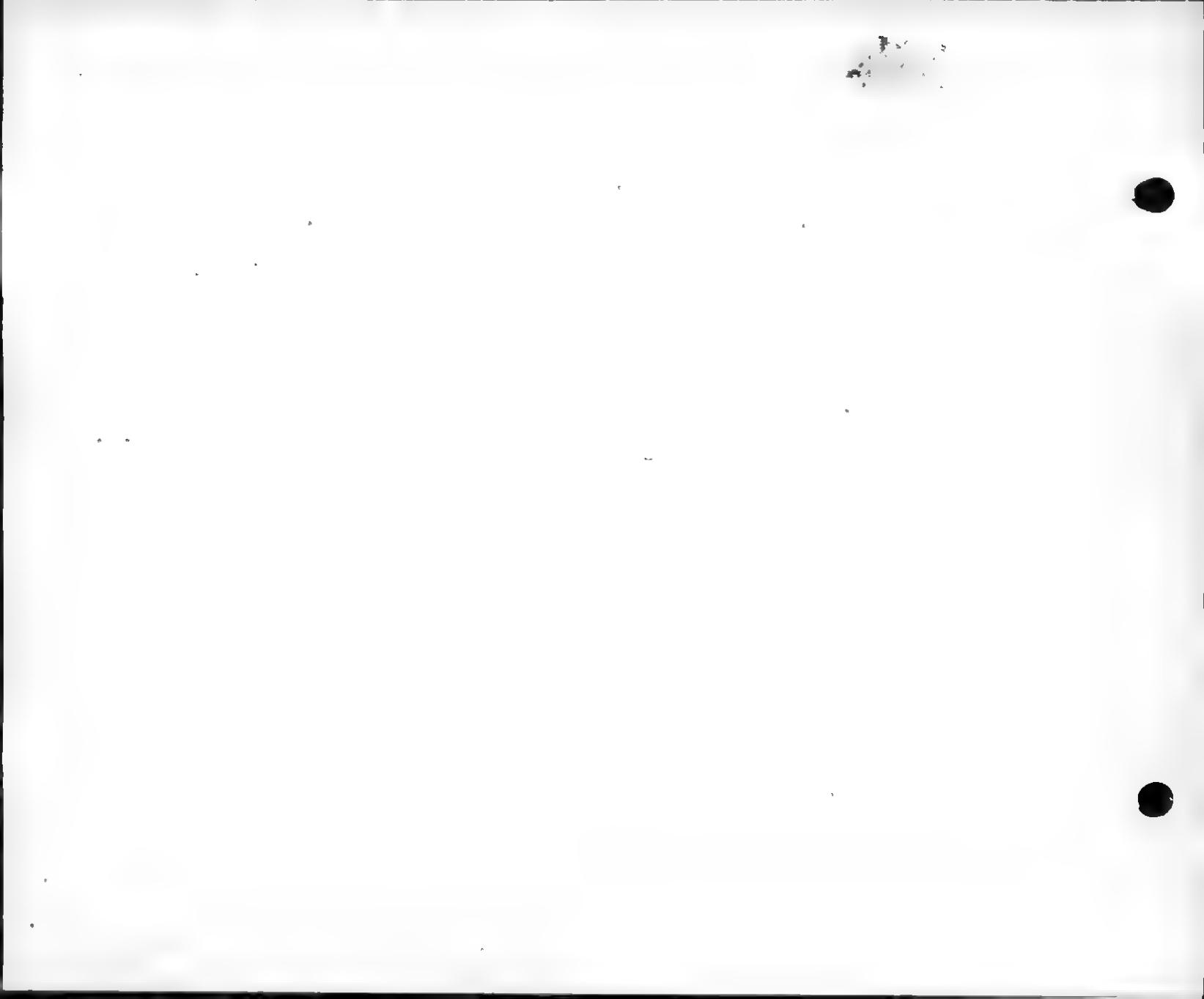
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 4 along with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

08380

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08369

1 PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN TB D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital		d. STREET ADDRESS R.F.D. 2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (First, Middle, Last) Henson Jones		4 DATE OF DEATH Month Day Year June 8, 1966	
5 SEX Male		6 COLOR OR RACE Negro	
7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8 WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9a. DATE OF BIRTH May 15, 1901		9b. AGE (In years as of birthday) 65 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry N. Jones		14. MOTHER'S MAIDEN NAME Susan Nichols	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 220-26-9137	
17. INFORMANT Mrs. Lizzie P. Jones		Address R.F.D. 2 Cambridge, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH Instnat.	
+201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/12/66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Fork Neck Cemetery		23d. LOCATION (City or Town) (County) (State) Dorchester County, Md.	
24. FUNERAL DIRECTOR St. Clair Funeral		25a. RECEIVED BY REGISTRAR DATE JUN 13 1966	
ADDRESS Cambridge, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



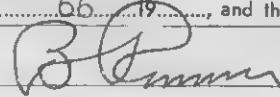
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, if any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08381 Item #1d Film 08370

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
DORCHESTER MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HURLOCK		b. COUNTY CAROLINE	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DENTON	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bellehaven Nursing Home		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) HARVEY		4. DATE OF DEATH JUNE 12 1966	
5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH NOV. 30 1890	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. AGE (in years at last birthday) 75 yrs.	
9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOSEPH LARAMORE	
14. MOTHER'S MAIDEN NAME LILLIE THOMAS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO	
16. SOCIAL SECURITY NO.		17. INFORMANT MRS. PEARL McALISTER, Denton, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH 1yr	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure, with - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cerebral Arteriosclerosis DUE TO } (c) Generalized Arteriosclerosis		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?Pulmonary Malignancy		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (we) attended the deceased from 6/6/66, 19, to 6/12/66, 19, that (I) (we) last saw the deceased alive on 66, 19, and that death occurred at M, from the causes and on the date stated above.	
22a. SIGNATURE 		22b. DATE SIGNED 6/14/66	
22c. PHYSICIAN'S NAME (Type) Harold R. Pittman, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) JUN 15 1966		23c. NAME OF CEMETERY OR CREMATORIAL DENTON	
23d. LOCATION (City, town or county) (State) DENTON, MD.		24. FUNERAL DIRECTOR'S SIGNATURE Charles Moore, Denton, Md.	
25a. ADDRESS		25b. REC'D. BY REGISTRAR JUN 20 1966	
25b. REGISTRAR'S SIGNATURE Charles J. Judge			



1

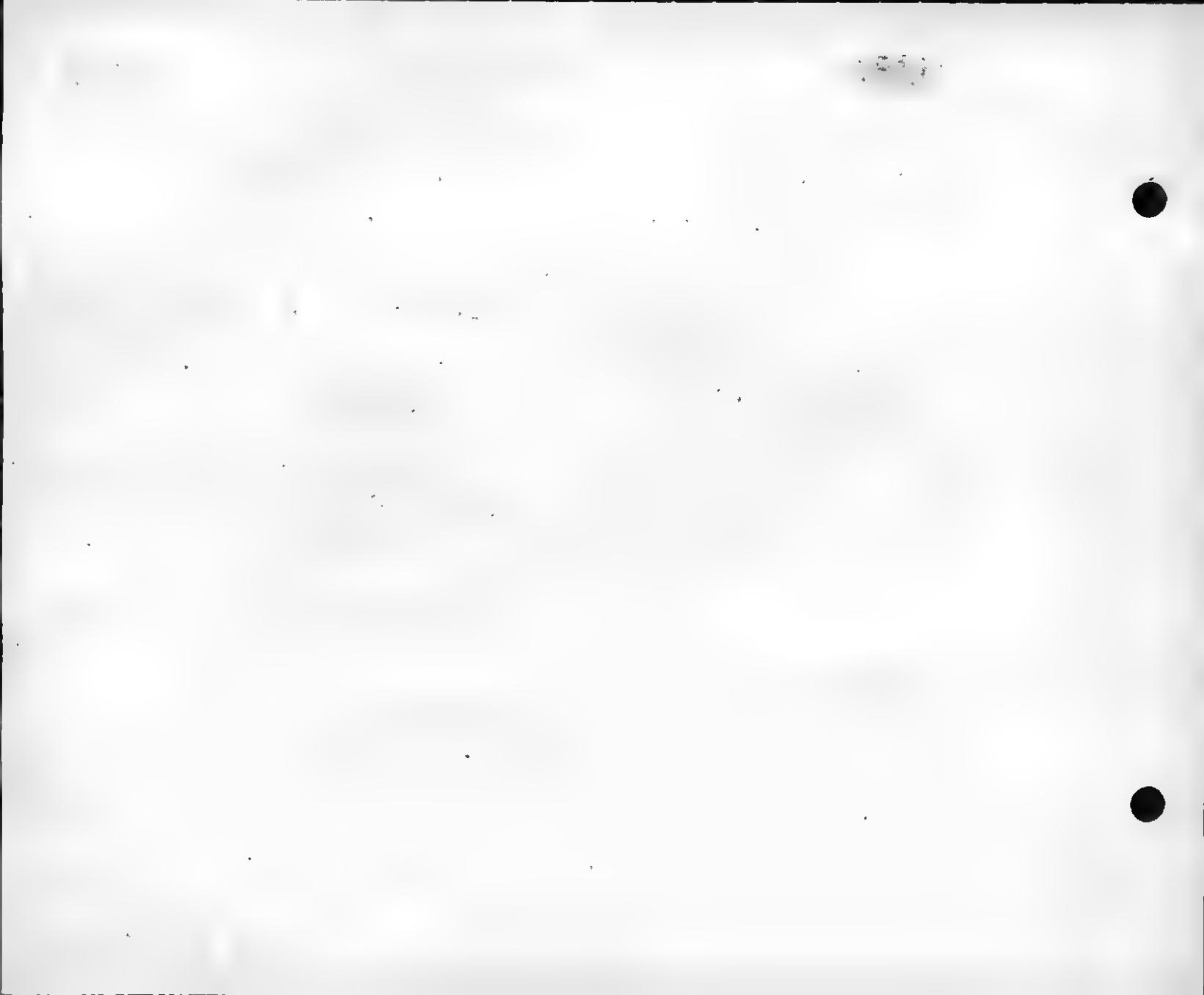
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08382 CERTIFICATE OF DEATH 118371

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE (RURAL)		c. LENGTH OF STAY IN b 7 MONTHS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VIENNA - Rural					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL			d. STREET ADDRESS ROUTE #L			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) RUTH		First MURPHY	Middle LEE	4. DATE OF DEATH JUNE 23, 1966	Month JUNE	Doy 23	Year 1966		
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1893	9. AGE (In years last birthday) 73 yrs.	10. CIVIL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	11. BIRTHPLACE (County & State, or foreign country) MARYLAND (Dorchester Co.)	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Daniel J. Murphy		14. MOTHER'S MAIDEN NAME Elizabeth Thompson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. --- 17. INFORMANT					
					Address RECORDS OF THE EASTERN SHORE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO --- INTERVAL BETWEEN CONSET AND DEATH 5 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mural thrombosis of right atria DUE TO --- 1 day (c) Senile cachexia DUE TO --- 3 years									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Vienna (County) Maryland (State) MD			
21. I certify that (I) (this hospital) attended the deceased from November 4, 1965 , to June 23, 1966 , that (I) (we) last saw the deceased alive on June 23, 1966 , and that death occurred at 10:30 A.M. , from causes and on the date stated above.									
22. SIGNATURE Carlos F. Barroso M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> DATE SIGNED 6-24-66									
22c. PHYSICIAN'S NAME (Type) CARLOS F. BARROSO M.D.		22d. ADDRESS EASTERN SHORE STATE HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 27, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Vienna Cemetery		23d. LOCATION (City or Town) Vienna (County) Maryland (State) MD			
24. FUNERAL DIRECTOR J. J. Hamptonson ADDRESS Federalburg, Md.		25a. REGD. BY REGISTRAR Charles Judy DATE JUN 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judy					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08372

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b Two Weeks		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fishing Creek			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital		d. STREET ADDRESS None			
3. NAME OF DECEASED (Type or print)	First OCTAVIA	Middle E.	Last MEEKINS		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 3, 1881		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
13. FATHER'S NAME Charles Q. Parks	14. MOTHER'S MAIDEN NAME Mary White	11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) No	16. SOCIAL SECURITY NO. 212-16-1950	17. INFORMANT Mrs. Burton Jackson, Fishing Creek, Md.	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH 2 days					
SUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Virus pneumonia</u> 5 days (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/1, 1966, to 6/6, 1966, that (I) (we) last saw the deceased alive on 6/6, 1966, and that death occurred at 9:30 AM, from the causes and on the date stated above.		22b. DATE SIGNED 6/7/66			
22a. SIGNATURE <u>Alfred R. Maryanov</u>		M.D. ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) ALFRED R. MARYANOV		22d. ADDRESS 610 RACE ST., CAMBRIDGE, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 8, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Hosier Memorial Cemetery	23d. LOCATION (City, town or county) (State) Fishing Creek, Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS		25a. REC'D BY REGISTRAR JUN 9 1966	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

1-
1-
1-
1-
1-

1
FOR STATE
HEALTH DEPT.

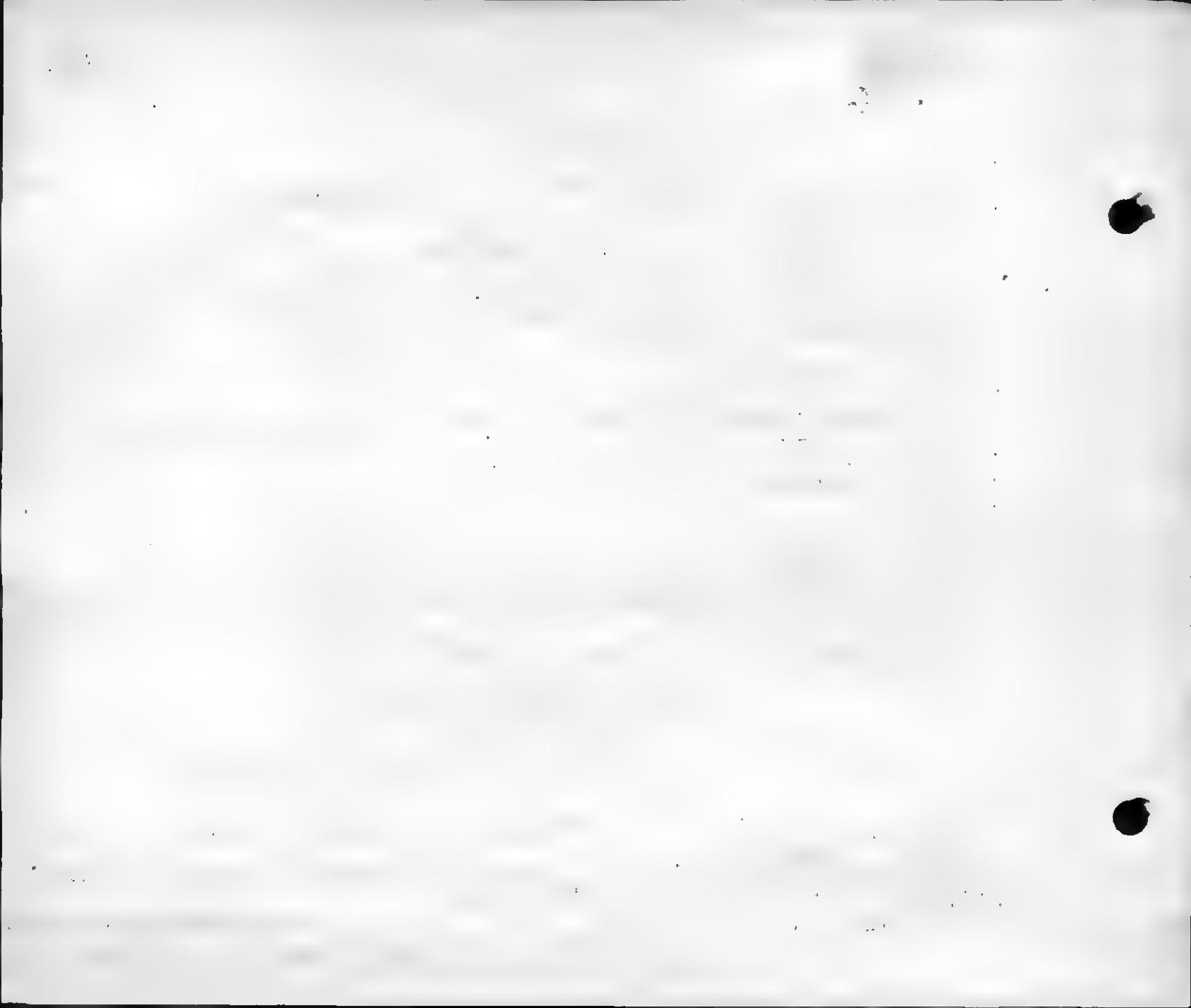
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118373

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residencia before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		d. STREET ADDRESS 307 Bunker Street	
3. NAME OF DECEASED (Type or print) ALGA		First ?	Middle NEIGHBORS
4. DATE OF DEATH June 8, 1966		5. SEX Male	6. COLOR OR RACE White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 11, 1900	
9. AGE (In years last birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown	11. BIRTHPLACE (State or foreign country) Easton, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Unk	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Artie Mitchell, Centreville, Maryland Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH Instant	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion		DUE TO 4201	
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.		DUE TO (b)	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <i>John Mace Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22f. DATE THEREOF Jun 11, 1966		Address (Street, city, town, or county) Spring Hill Cemetery	
22g. LOCATION (City, town, or county) Easton, Maryland		24a. REC'D BY REGISTRAR JUN 13 1966	
23. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

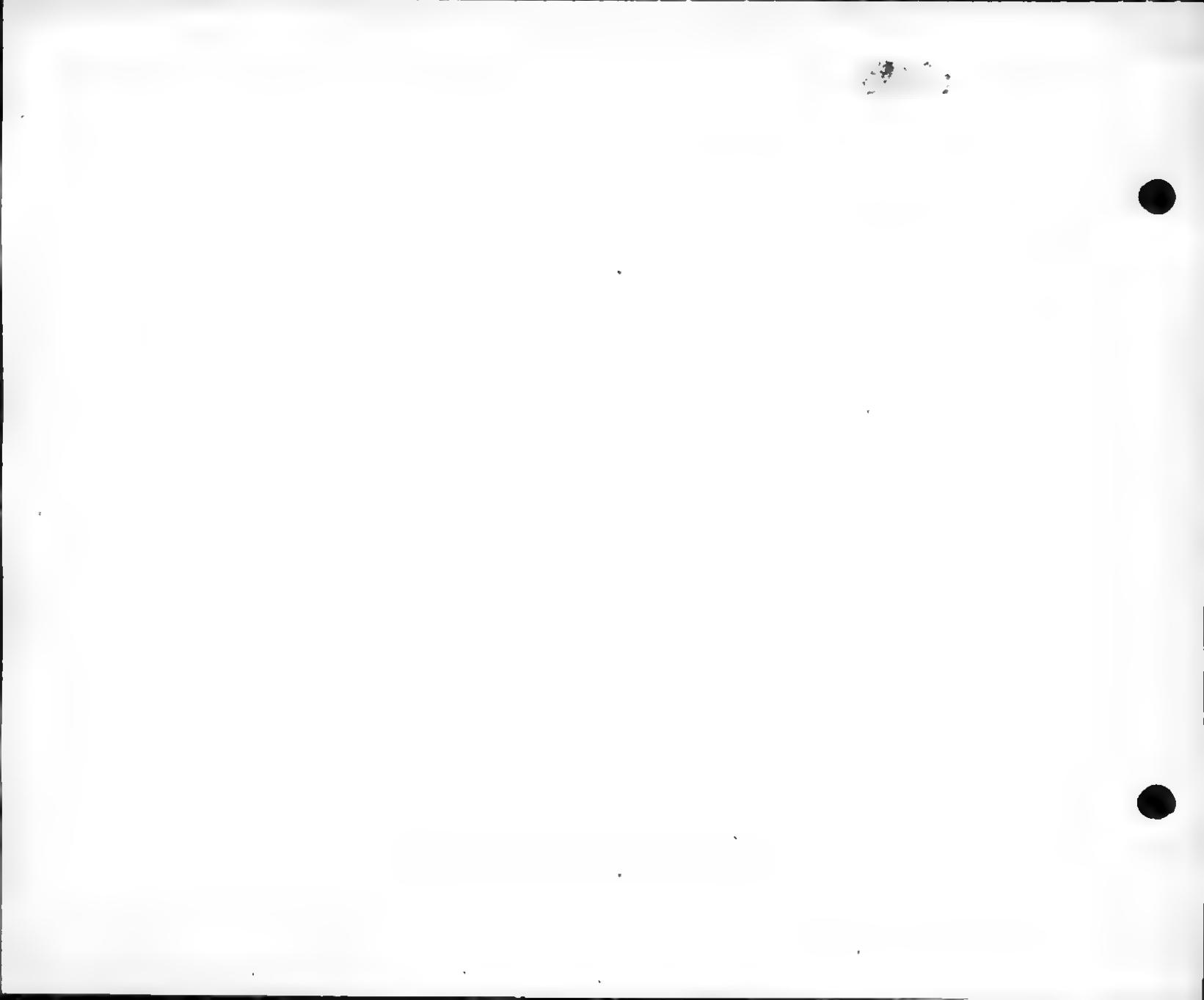
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

08385

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08374

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased resided, if institution, residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Ind. Hospital D.O.A.		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Clara First E. Middle Sampson Last Opfer		4. DATE OF DEATH Month 6 Day 29 Year 1966	
5. SEX Female 6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Oct. 2, 1920		9. AGE (In years last birthday) 45 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Milbourn		14. MOTHER'S Maiden Name Clara Styles	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO —	
17. INFORMANT Albert Opfer.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute hemorrhagic pancreatitis		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-3-66	
23c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Booker T. West		25a. REC'D BY REGISTRAR DATE JUL 5 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			



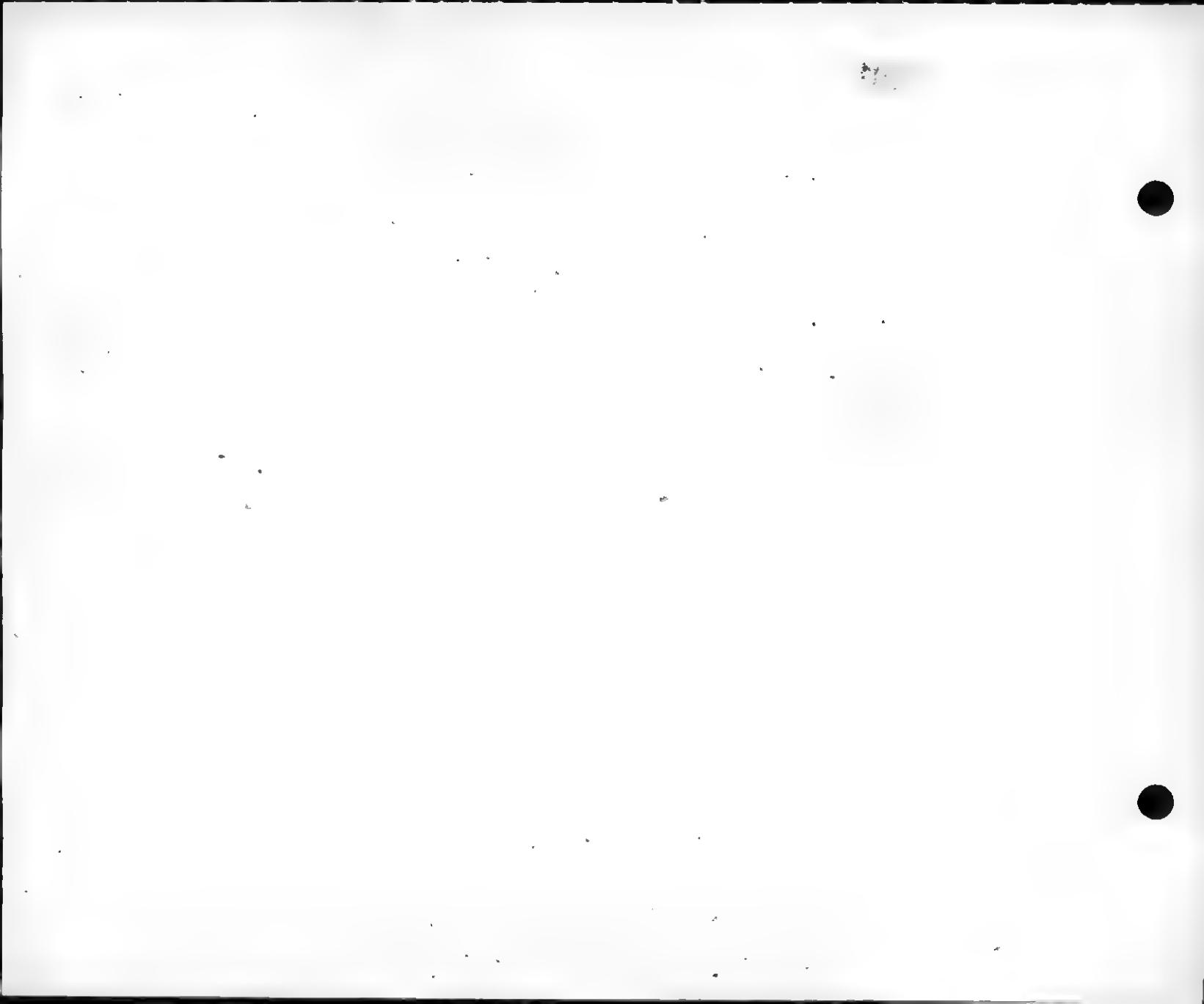
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
FOR STATE
HEALTH DEPTTO **DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.TO **FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <i>Dorchester</i>		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Dor</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. LENGTH OF STAY IN b <i>10 hrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Cambridge Maryland</i>		e. STREET ADDRESS <i>—</i>	
3 NAME OF DECEASED (Type or print) <i>Margaret Dorothy Osborne</i>		4 DATE OF DEATH Month <i>6</i> Day <i>20</i> Year <i>1966</i>	e. S. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5 SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	8 DATE OF BIRTH <i>2/16/1889</i>
9 AGE (In years less birthday) <i>77</i>	10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11 BIRTHPLACE (State or foreign country) <i>Illinois</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	13. FATHER'S NAME <i>Robert Osborne</i>		
14. MOTHER'S MAIDEN NAME <i>Elizabeth Allardice</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		
16. SOCIAL SECURITY NO <i>—</i>		17. INFORMANT <i>George Osborne, Hurlock, Md.</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)
CORONARY OCCLUSION			INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>
20f. (City or town) <i>—</i>		(County) <i>—</i> (State) <i>—</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) <i>JOHN MACE JR.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>—</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6/22/66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>East New Market</i>		23d. LOCATION (City or Town) (County) <i>—</i> (State) <i>—</i>	
24. FUNERAL DIRECTOR <i>John Mace Jr.</i>		25a. REC'D BY REGISTRAR JUN 23 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jr.</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If City delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

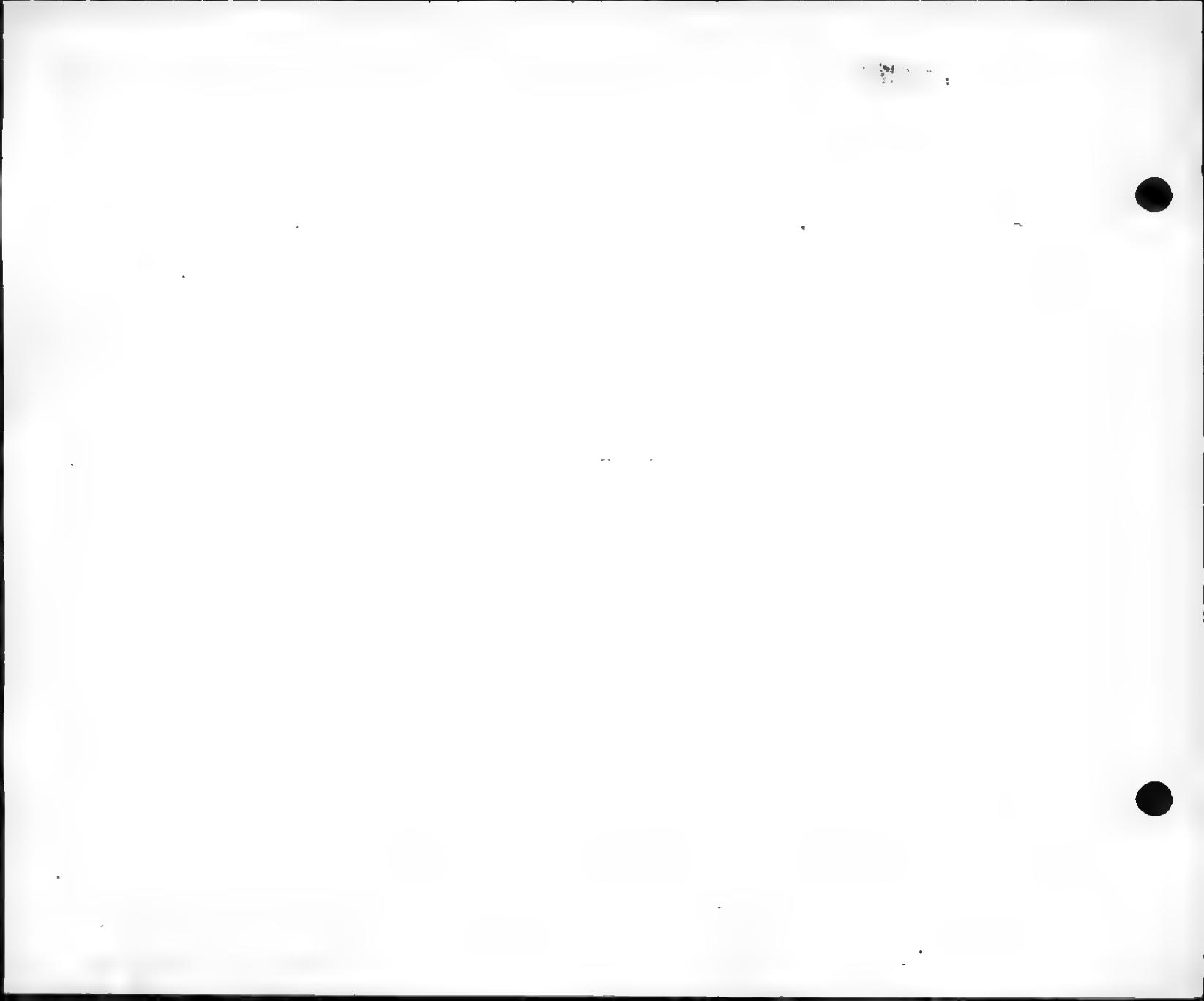
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08387

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08376

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN b. 15 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 610 Muir St.				d. STREET ADDRESS 610 Muir St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Edwillie		First	Middle	Last	4. DATE OF DEATH June 8, 1966	Month	Day	Year				
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH March 10, 1933	9. AGE (in years last birthday) 33 yrs	10. UNDER 1 YEAR Months	11. UNDER 24 HRS Days	12. UNDER 24 HRS Hours				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME Buford Palmer				14. MOTHER'S MAIDEN NAME Lillian Jerdon								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIA. SECURITY NO None		17. INFORMANT 218-30-2296 Mrs. Agnes Palmer		Address Cambridge, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Coronary occlusion (c)		INTERVAL BETWEEN ONSET AND DEATH Inst.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Mace Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cambridge, Dor. Md.		22. DATE SIGNED 6/10/66								
23a. BURIAL/CREMATION, REMOVAL (Society) Burial		23b. DATE THEREOF 6/12/66	23c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery	23d. LOCATION (City or Town) Cambridge, Dor. Md.		(County)	(State)					
24. FUNERAL DIRECTOR St. Clair Funeral		ADDRESS Cambridge, Md.	25a. REC'D BY REGISTRAR JUN 13 1966		25b. REGISTRAR'S SIGNATURE Charles J. ...							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08388

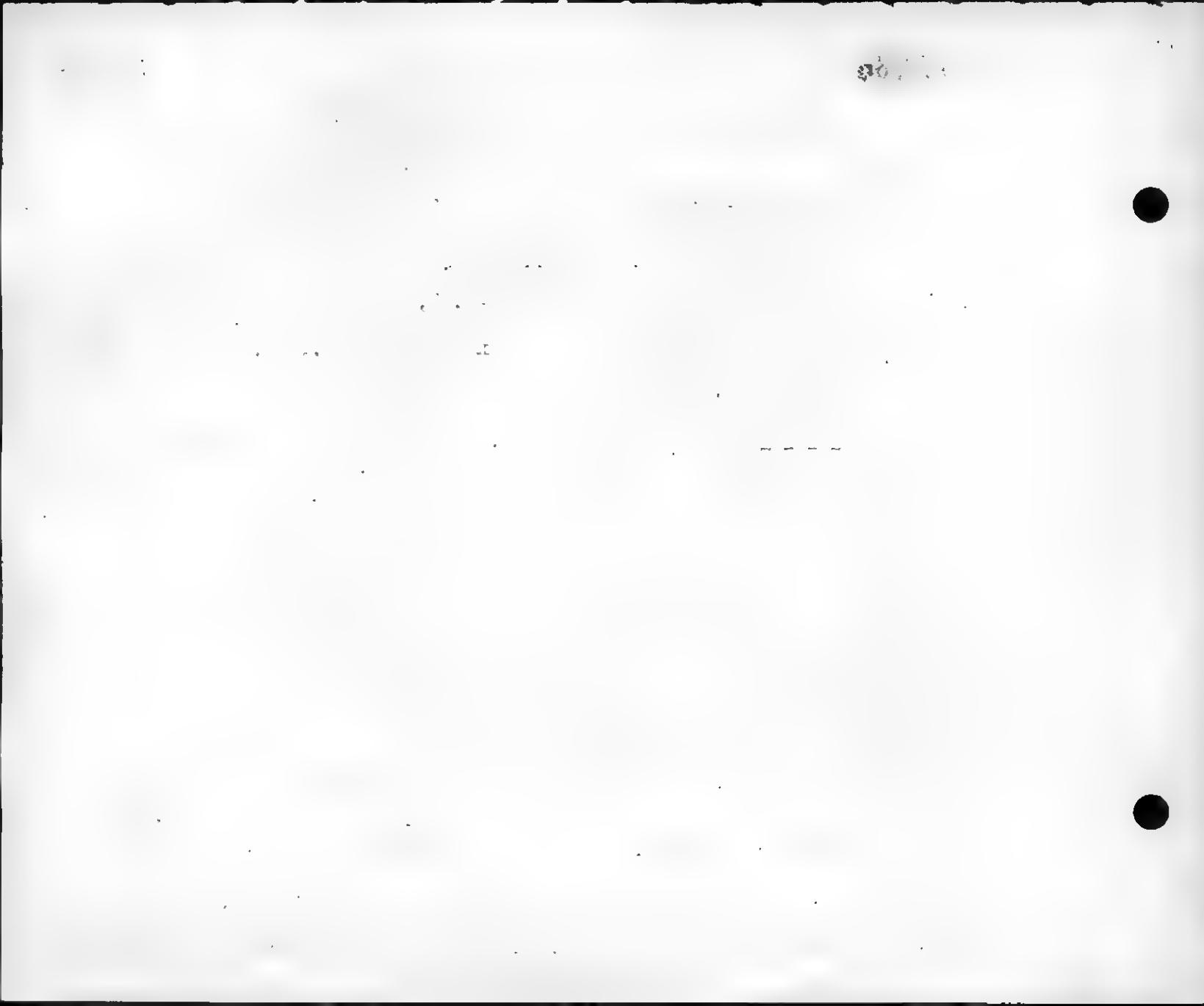
CERTIFICATE OF DEATH

08377

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 30 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital				d. STREET ADDRESS 507 Academy Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First LAURA	Middle C.	Last PARKS	4. DATE OF DEATH	Month June 18	Day 19	Year 66
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1880	9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William C. Dean		14. MOTHER'S MAIDEN NAME Laura Robinson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Wilson Wheatley, Cambridge, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Mycocardial Infarction Cerebral Hemorrhage Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day 1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4130 1/2		20f. (City or town) (County) (State) 6/18/66 19 6/18/66 19	
21. I certify that (I) (this hospital) attended the deceased from 6/18/66, 19, to 6/18/66, 19, that (I) (we) last saw the deceased alive on 6/18/66, 19, and that death occurred at 10 AM, from the causes and on the date stated above.							
22a. SIGNATURE Lawrence Maryanov		22b. DATE SIGNED 6/21/66					
22c. PHYSICIAN'S NAME (Type) Lawrence Maryanov, MD		22d. ADDRESS Race Street, Cambridge, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 21, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park		23d. LOCATION (City, town or county) Cambridge, Maryland (State)	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS		25a. REC'D BY REGISTRAR JUN 22 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

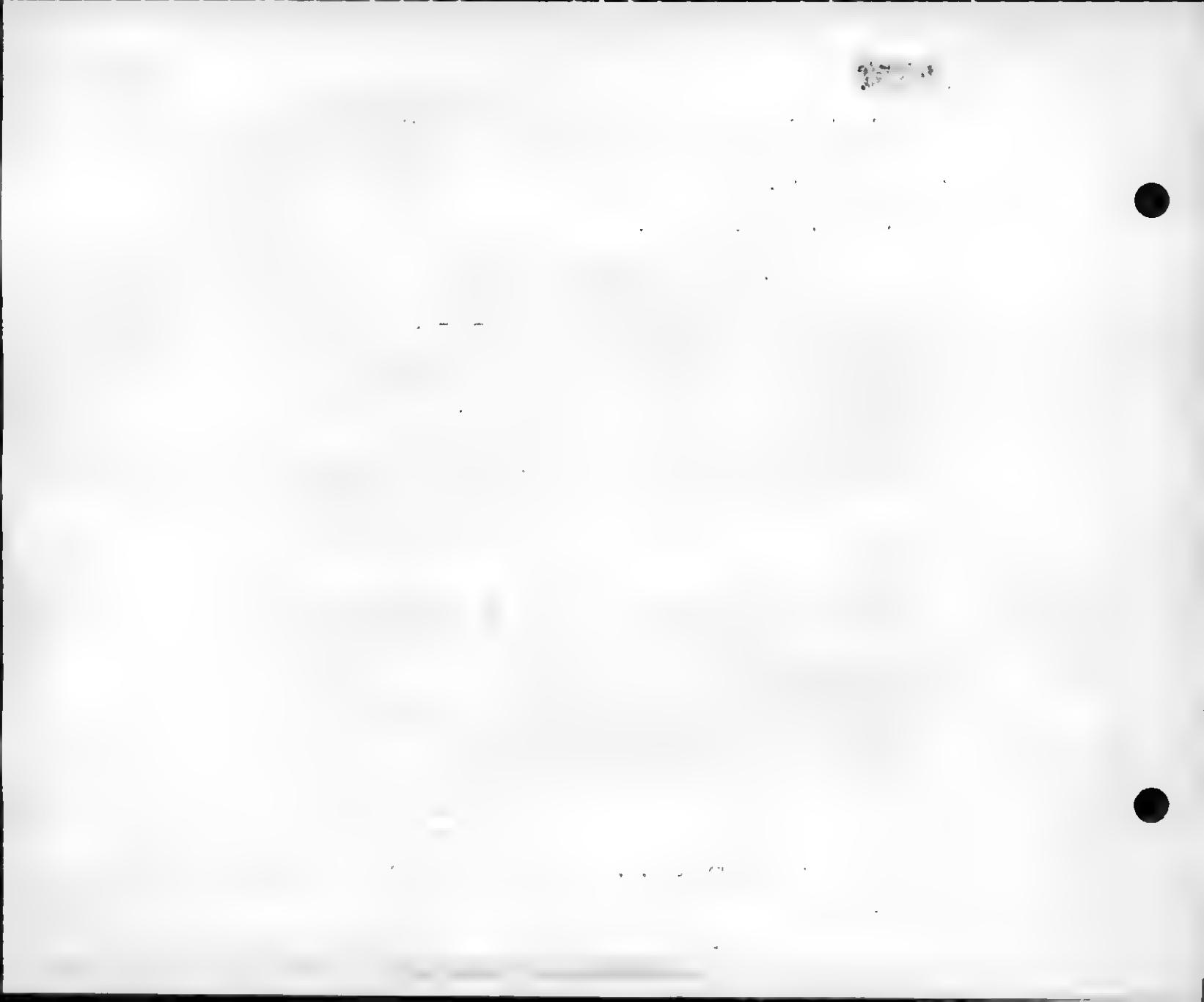
08389

CERTIFICATE OF DEATH

11378

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 may be retained by the hospital or attending physician.
3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge (rural)		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Dorchester							
c. LENGTH OF STAY IN 1b 8 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital		d. STREET ADDRESS 111 Oakley Street							
3. NAME OF DECEASED (Type or print) Margaret Spence Phelps		First Margaret	Middle Spence	Last Phelps	4. DATE OF DEATH June 21 1966	Month June	Day 21	Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01-03-71	9. AGE (In years last birthday) 92 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Spence					14. MOTHER'S MAIDEN NAME Mary Henry				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO 111-11-1111				
17. INFORMANT John Spence					Address Records of the Eastern Shore State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO stating the underlying cause lost (c) DUE TO stating the underlying cause lost CONGESTIVE HEART FAILURE ANTERIOSCEROTIC HEART DISEASE									
INTERVAL BETWEEN ONSET AND DEATH 4 hours.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. June 21 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cambridge		(County) Dorchester	
(State) Maryland									
21. I certify that (I) (this hospital) attended the deceased from 10 - 4 , 19 65 , to 6-21 , 19 66 that (I) (we) last saw the deceased alive on June 21 1966 , and that death occurred at 6:43 PM , from causes and on the date stated above.									
22a. SIGNATURE C. F. Barnoso		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 6-21-66							
22c. PHYSICIAN'S NAME (Type) Carlos Barnoso M.D.		22d. ADDRESS Eastern Shore State Hospital							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 6/24/66		23c. NAME OF CEMETERY OR CREMATORIUM Eastern Shore State Hospital		23d. LOCATION (City or Town) Cambridge		(County) Dorchester	
24. FUNERAL DIRECTOR Howard H. Miller		ADDRESS 111 Oakley Street		25a. REC'D. BY REGISTRAR JUN 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

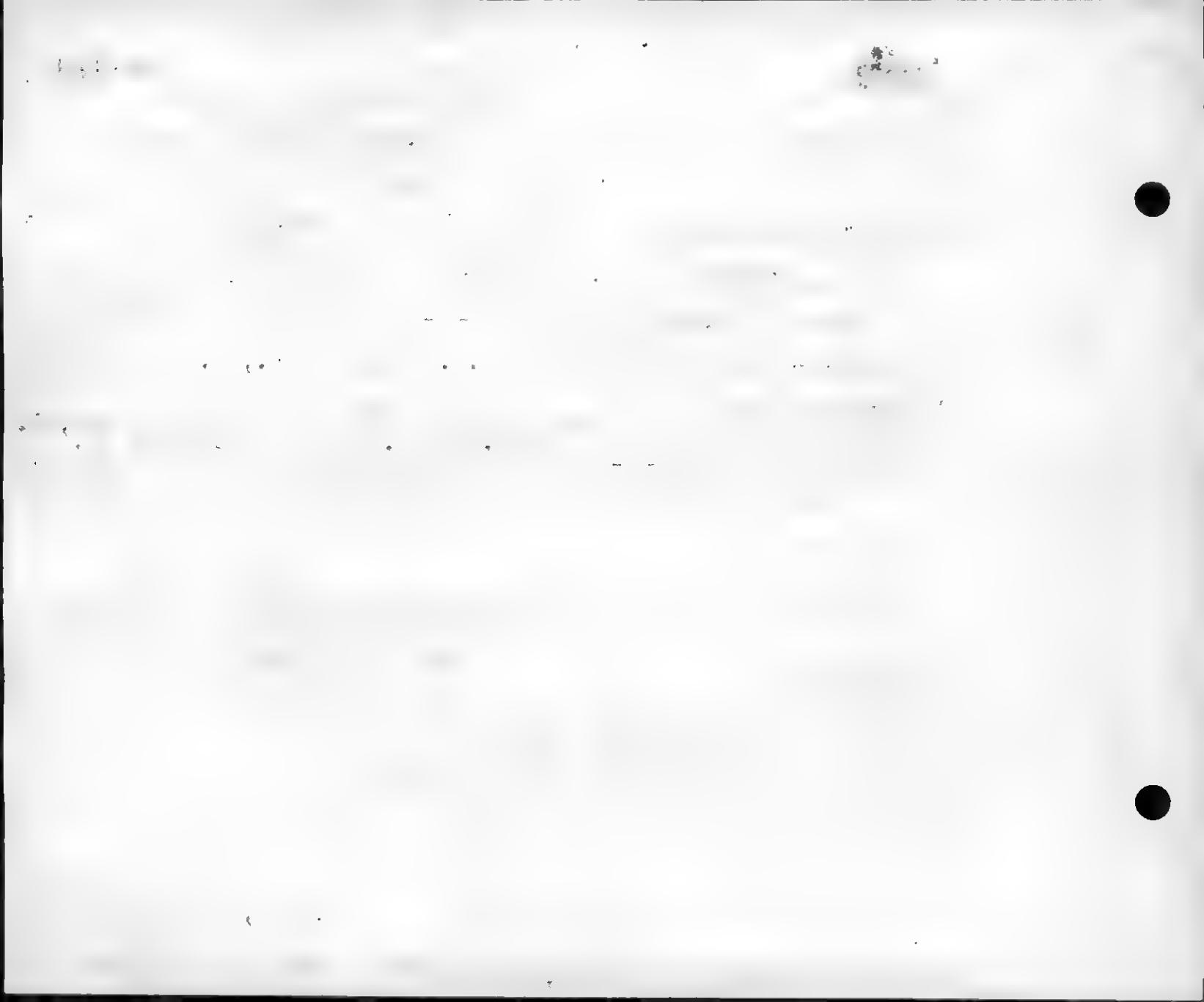


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~not~~ write carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge (rural)				c. LENGTH OF STAY IN lb 22 months				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital				d. STREET ADDRESS Bradley Street				e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Carlton	Middle Lee	4. DATE OF DEATH June 5 1966		Month	Day	Year			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-27-94	9. AGE (in years lost birthday) 71 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS DAYS DAYS HOURS MIN.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor - Construction				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) R.D. #Wicomico Co., Md.			
13. FATHER'S NAME William Phillips				14. MOTHER'S MAIDEN NAME Roxie Phillips Phillips				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-11-1069		17. INFORMANT Mrs. Rita M. Trice-712 Ferndale Rd.		Address Salisbury, Md.					
Records of the Eastern Shore State Hospital											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia INTERVAL BETWEEN DAYS AND DEATH day											
493X Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day Year Hour a.m. P.M. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 9:00 M, from causes and on the date stated above.											
22a. SIGNATURE Delia M. Dominguez											
22b. DATE SIGNED 6-6-66											
22c. PHYSICIAN'S NAME (Type) FELIPE M. DOMINGUEZ				22d. ADDRESS E.S.S.H.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF June 8/1966		23c. NAME OF CEMETERY OR CREMATORIUM Hebron Cemetery				23d. LOCATION (City or Town) (County) (State) Hebron, Maryland			
24. FUNERAL DIRECTOR Holloway & Company ADDRESS SALISBURY, MARYLAND											
25a. REC'D BY REGISTRAR JUN 7 1966				25b. REGISTRAR'S SIGNATURE Charles Judge							
VR A15 (4) 20 M 1/66											



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
08391

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

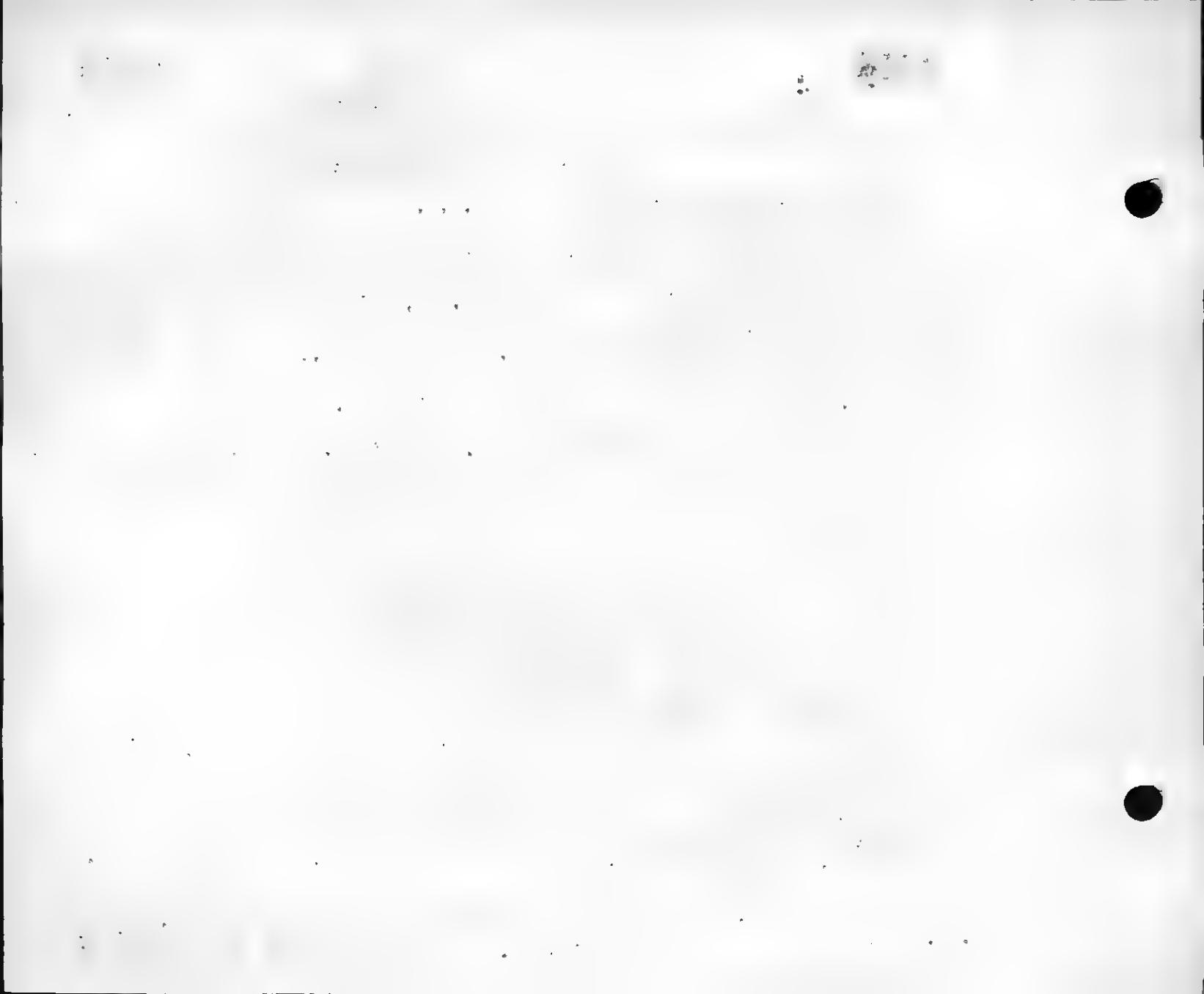
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

08380

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1D 13 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market		07-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital		d. STREET ADDRESS R.F.D. # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Reuben	Middle Andrew	Last Pinder	4. DATE OF DEATH Sept. 16, 1914	Month June	Day 5	Year 1966
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1914	9. AGE (in years last birthday) 51	10. UNDER 1 YEAR Months 51	11. UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Marvil Package Co.		11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel A. Pinder		14. MOTHER'S MAIDEN NAME Millie F. Stanley		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-28-4784	
17. INFORMANT Mrs. Luhittie E. Pinder, East New Market,		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Bleeding		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		Address Maryland	
		DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from May 23, 1966 to June 5, 1966 that (I) (we) last saw the deceased alive on June 5, 1966 , and that death occurred at 11:10 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 6-5-66					
22a. SIGNATURE <i>John E. Pinder</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) J. Elwin Pascott, M.D.		22d. ADDRESS 727 Fine St., Cambridge, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 9, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Thompsontown Cemetery		23d. LOCATION (City, town or county) (State) East New Market, Maryland	
24. FUNERAL DIRECTOR J. W. Frampton and Son, Federalsburg, Md.		ADDRESS Pine Street		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
				DATE JUN 15 1966			



FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

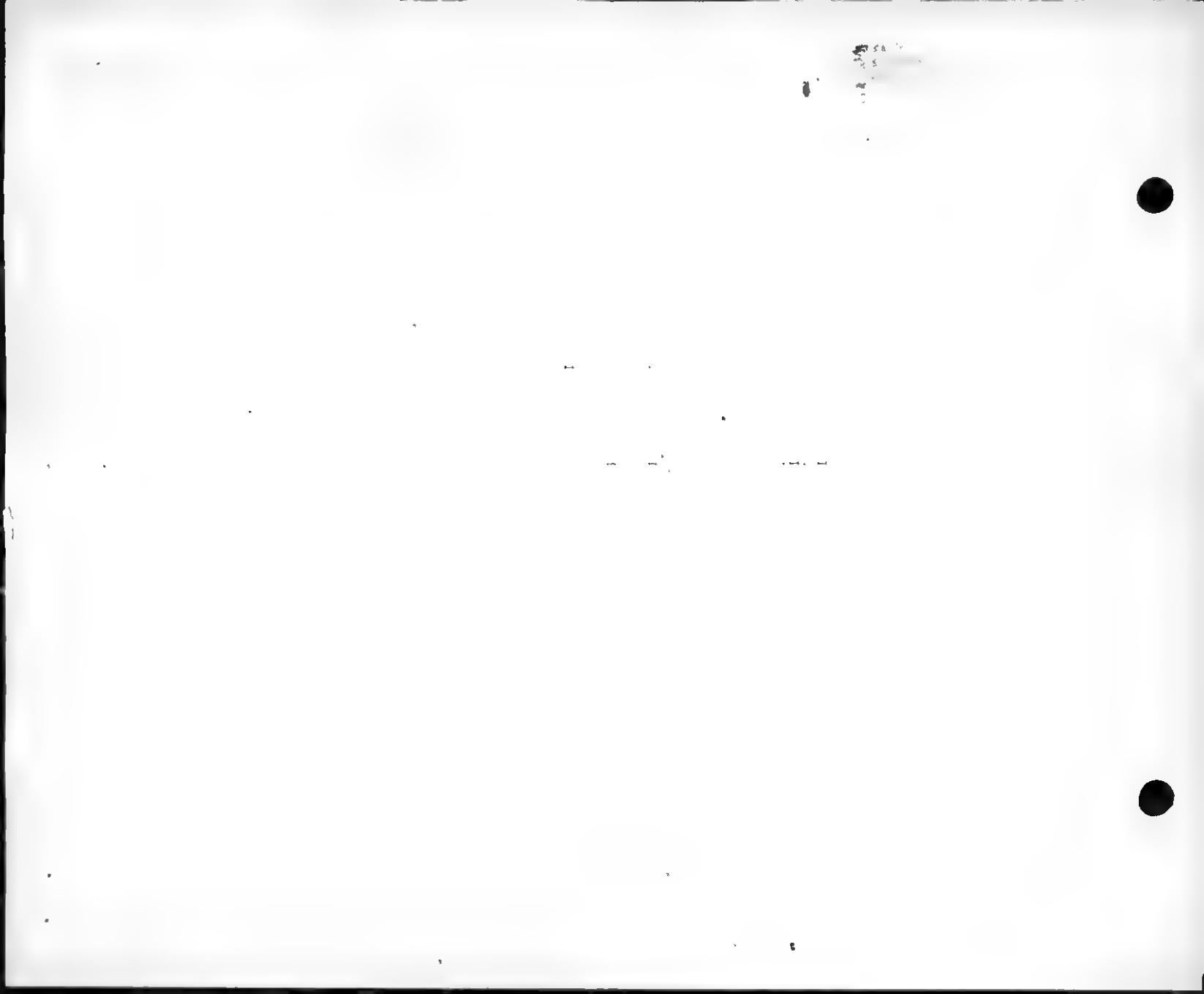
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08392

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08381

1. PLACE OF DEATH a. COUNTY Dorchester			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN Tb Life		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1014 Pine Street			d. STREET ADDRESS 1014 Pine Street		
3. NAME OF DECEASED (Type or print) Sarah			First Conoway	Middle Pinder	4. DATE OF DEATH June 16 1966
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> WIDOWED X	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1889
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			9. AGE (In years last birthday) 76 yrs		
10b. K ND OF BUSINESS OR INDUSTRY -----			11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Charles W. Demby			14. MOTHER'S MAIDEN NAME Annetta Conoway		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOC. A. SECURITY NO 217-10-8013 D Loretta Young		
17. INFORMANT -----			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			DUE TO (b) DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John Mace, Jr.</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		
EXAMINER'S NAME (Type) John Mace, Jr.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
Address (Street, city, town, or county) 6/20/66 Cambridge, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 6/18/66		
23c. NAME OF CEMETERY OR CREMATORIAL Waugh			23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR Frederick C. St. Clair			ADDRESS Cambridge Dor. Md.		
			25a. REG'D BY REGISTRAR JUN 27 1966		
			25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

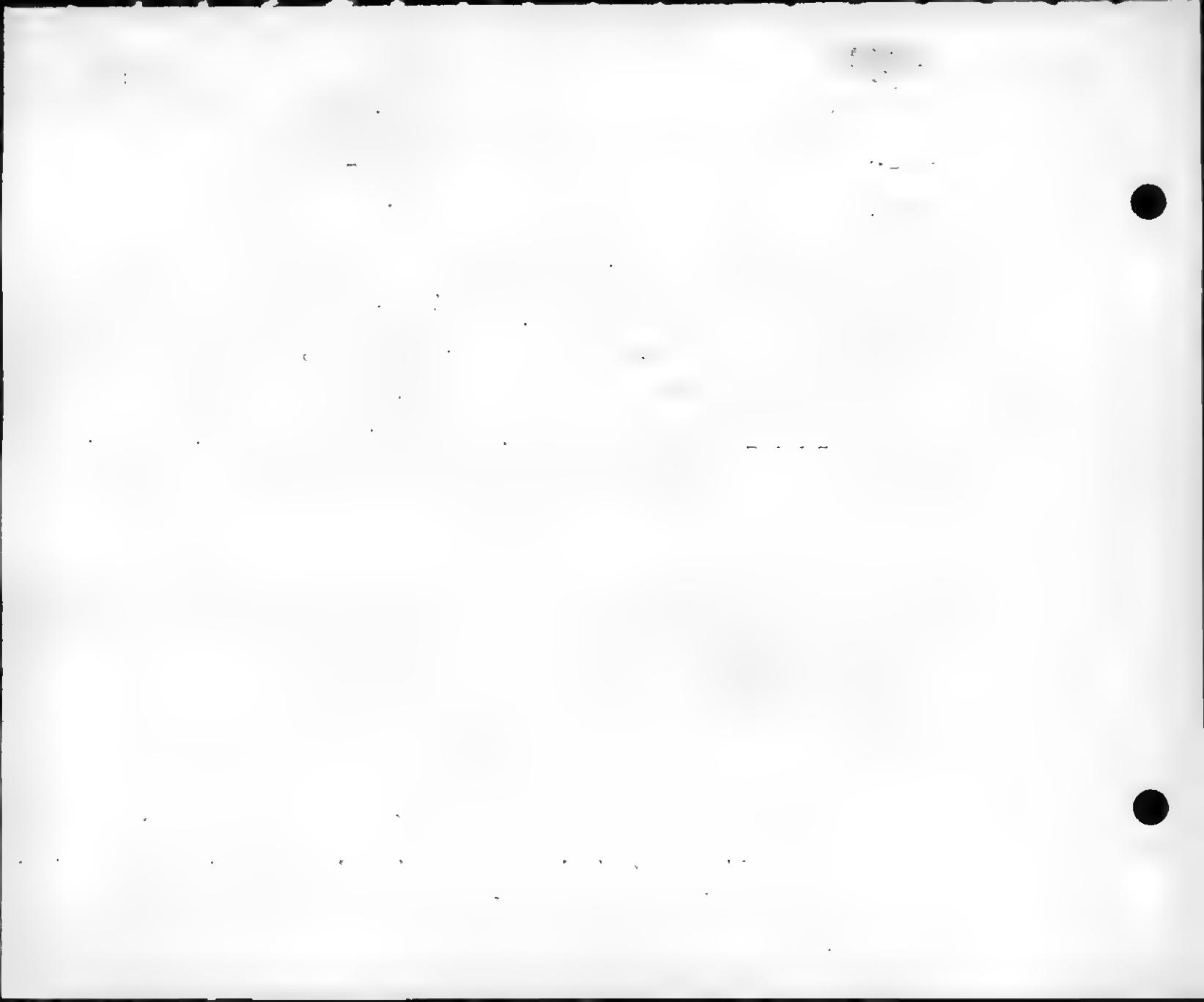
08393

08382

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Wingate		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) None		d. STREET ADDRESS None	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ARCHIE	Middle I.	Last POWLEY
4. DATE OF DEATH June 29, 1966	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1884
9. AGE (in years last birthday) 82 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charlie Jones	14. MOTHER'S MAIDEN NAME Mary Dean		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Mr. Reginald Powley, Wingate, Maryland	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYELOGENOUS LEUKEMIA			
11 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from 2-12-65, 19, to 6-29-66, 19, that (II) (we) last saw the deceased alive on 6-13-66, 19, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Albert E. Bunker</i>		22b. DATE SIGNED 7-1-66	
22c. PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M. D.	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 200 Md. Ave., Cambridge, Maryland 21613	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 1, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park	23d. LOCATION (City, town or county) Cambridge, Maryland
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland	ADDRESS	25a. REC'D BY REGISTRAR DATE JUL 6 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in place of item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

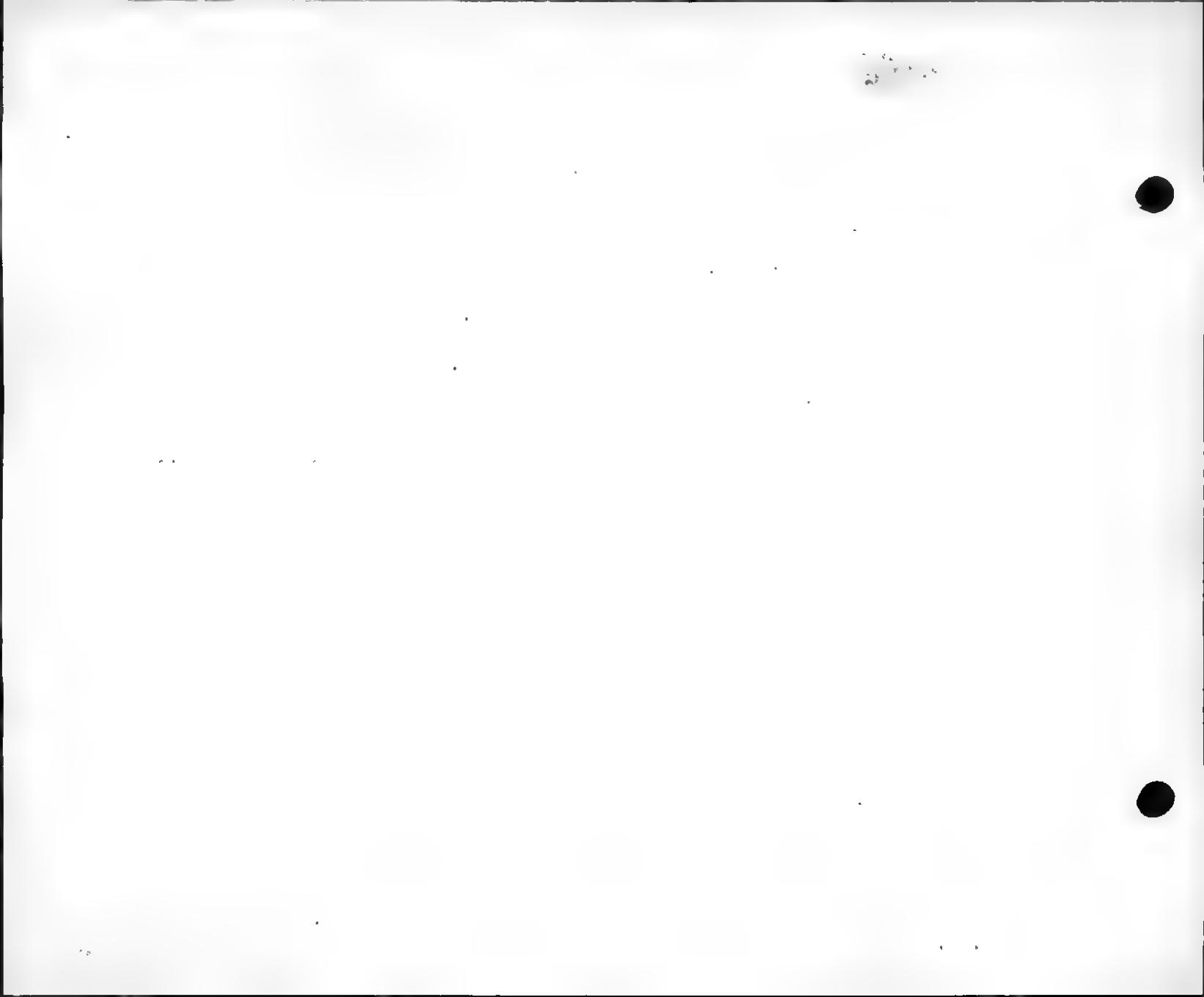
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

08394

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18383

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased resided if institution residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural	
c. LENGTH OF STAY IN lb 8 months		d. STREET ADDRESS Rhodesdale - Vienna Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rhodesdale - Vienna Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Herbert	Middle Johnson	Last Prince
4. DATE OF DEATH Month June	Day 21	Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 31, 1942
9. AGE (In years last birthday) 23	10. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) St. George, South Carolina	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Willie Prince	14. MOTHER'S Maiden Name Murdis Johnson	15. ADDRESS Roosevelt Mitchell, Vienna, Md., RFD #1	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		17. SOCIAL SECURITY NO Unknown	18. INFORMANT Roosevelt Mitchell, Vienna, Md., RFD #1
19. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carbon monoxide poisoning		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) carbon monoxide poisoning.			
DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) Burned in car.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6/21 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street
20f. (City or town) Rhodesdale		(County) Dor.	
(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Pete W. Rieckert</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address: <i>St. George, South Carolina</i>	
22. DATE SIGNED 6-21-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF June 23, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Shady Grove Cemetery
23d. LOCATION (City or Town) St. George, South Carolina		(County) South Carolina	
(State) South Carolina			
24. FUNERAL DIRECTOR <i>J. J. Frampom and Son, Federalsburg, Maryland</i>		25a. ADDRESS <i>from Frampom</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
6M 1/66		25c. REC'D BY REGISTRAR JUN 23 1966	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08395

118384

1. PLACE OF DEATH
a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cambridge

c. LENGTH OF STAY IN 1b

Years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

102 West End Ave.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Dorchester

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cambridge

d. STREET ADDRESS

102 West End Ave.

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First
Georgia A. Pritchett

Middle

Last

4. DATE
OF
DEATH

Month

Day
Year

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED

8. DIVORCED

9. DATE OF BIRTH

4/4/1878

9. AGE (in years
last birthday)

88

10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housework

10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Dorchester Maryland

12. CITIZEN OF WHAT
COUNTRY?

USA

13. FATHER'S NAME

John H. Insley

14. MOTHER'S MAIDEN NAME

Elizabeth Todd

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes give war or dates of service)

no

16. SOCIAL SECURITY NO.

113-18-4991

17. INFORMANT

Mrs. Everest Newnam, Easton, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DOUE TO

Conditions, If any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DOUE TO

(c)

Anemia & Anemia

Atus salutis (CD)

INTERVAL BETWEEN
ONSET AND DEATH

2 mos

?

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
DR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar 1964 to 6/11 1968, that (I) (we) last
saw the deceased alive on 6/11/68 19 19, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

James L. Thompson
22c. PHYSICIAN'S
NAME (Type)

M.D. ATTENDING
PHYS.

ME.O.
DIRECTOR

STAFF
PHYS.

22d. ADDRESS

22b. DATE SIGNED

Cambridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

6/3/1966

23c. NAME OF CEMETERY OR CREMATORIAL

Dorchester Memorial

23d. LOCATION (City, town or county) (State)

Cambridge, Md.

24. FUNERAL DIRECTOR

MAURICE E. NEWNAM & SON, Easton, Md.

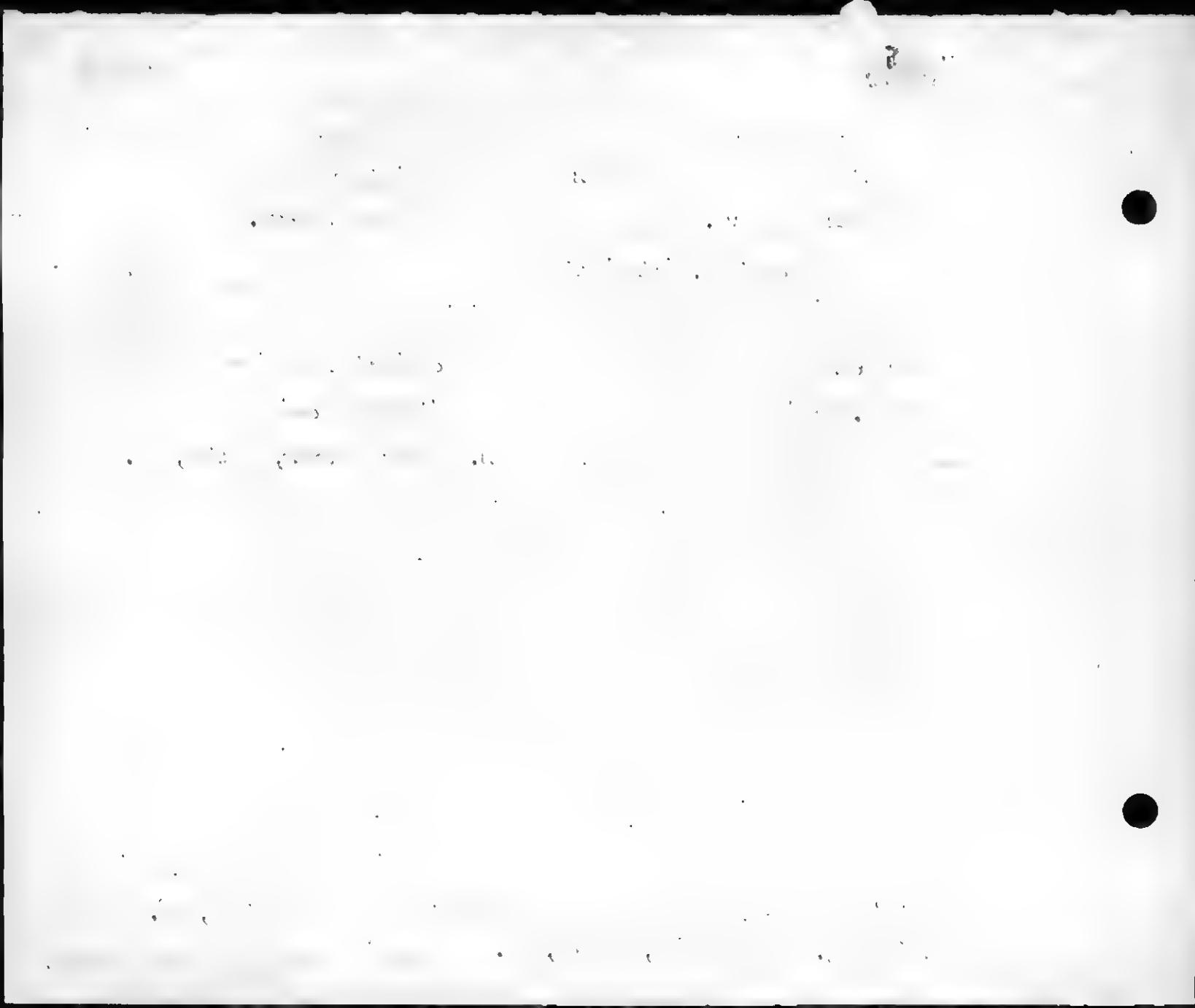
ADDRESS

25a. REC'D BY REGISTRAR

JUN 3 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Copy pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

08396

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118385

PLACE OF DEATH

a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge

c. LENGTH OF STAY IN lb

Life

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Cambridge Maryland Hospital

3. NAME OF
DECEASED
(Type or print)

First
James

Middle

Last
Ryder

4. DATE
OF
DEATH
June

Month
5
Day
19
Year
66

5. SEX

Male

6. COLOR OR RACE

Negro

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Oct. 8, 1892

9. AGE (In years
last birthday)

73
yrs.

10. IF UNDER 1 YEAR

Months
Days

11. IF UNDER 24 MRS.

Hours
Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Levin H. Ryder

Maryland

USA

14. MOTHER'S MAIDEN NAME

Eliza Pinder

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

Yes

16. SOCIAL SECURITY NO.

W. W. I

17. INFORMANT

Eva Tubman

Cordtown, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary occlusion

4201
DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH
30 Mins.

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)
While
at work Not While
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

19

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

John Mace Jr. M.D.

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

6/10/66

Address (Street, city, town, or county) Cambridge, Md.

(State)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

6/9/66

22c. NAME OF CEMETERY OR CREMATORI

Cordtown

22d. LOCATION (City, town, or county)

Dorchester Co. Md.

(State)

23. FUNERAL DIRECTOR

Frederick C. St. Clair

Frederick C. St. Clair

ADDRESS

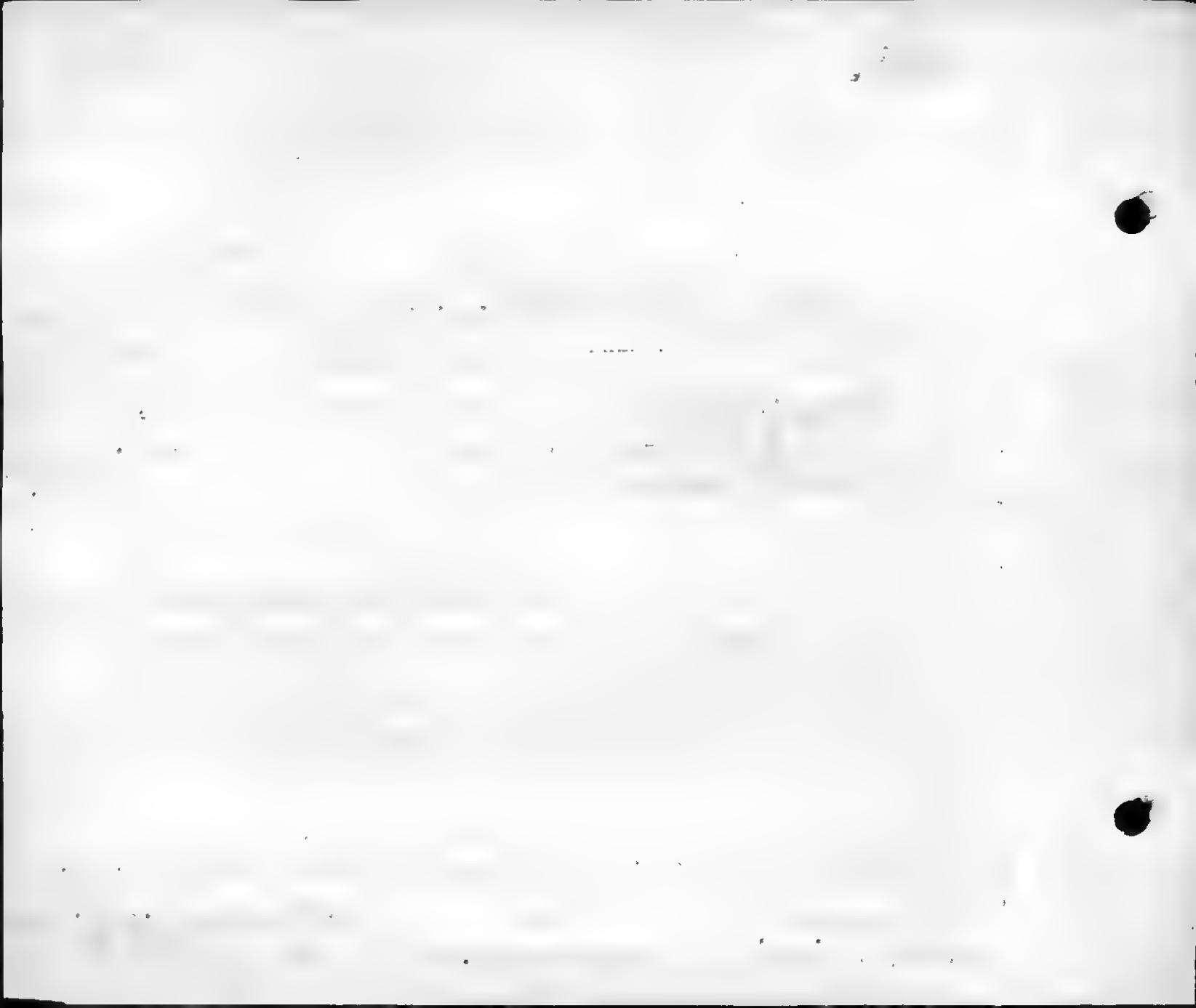
Cambridge, Md.

24a. REC'D. BY REGISTRAR

JUN 13 1966

24b. REGISTRAR'S SIGNATURE

Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film G3/8 7/8/66 mn

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

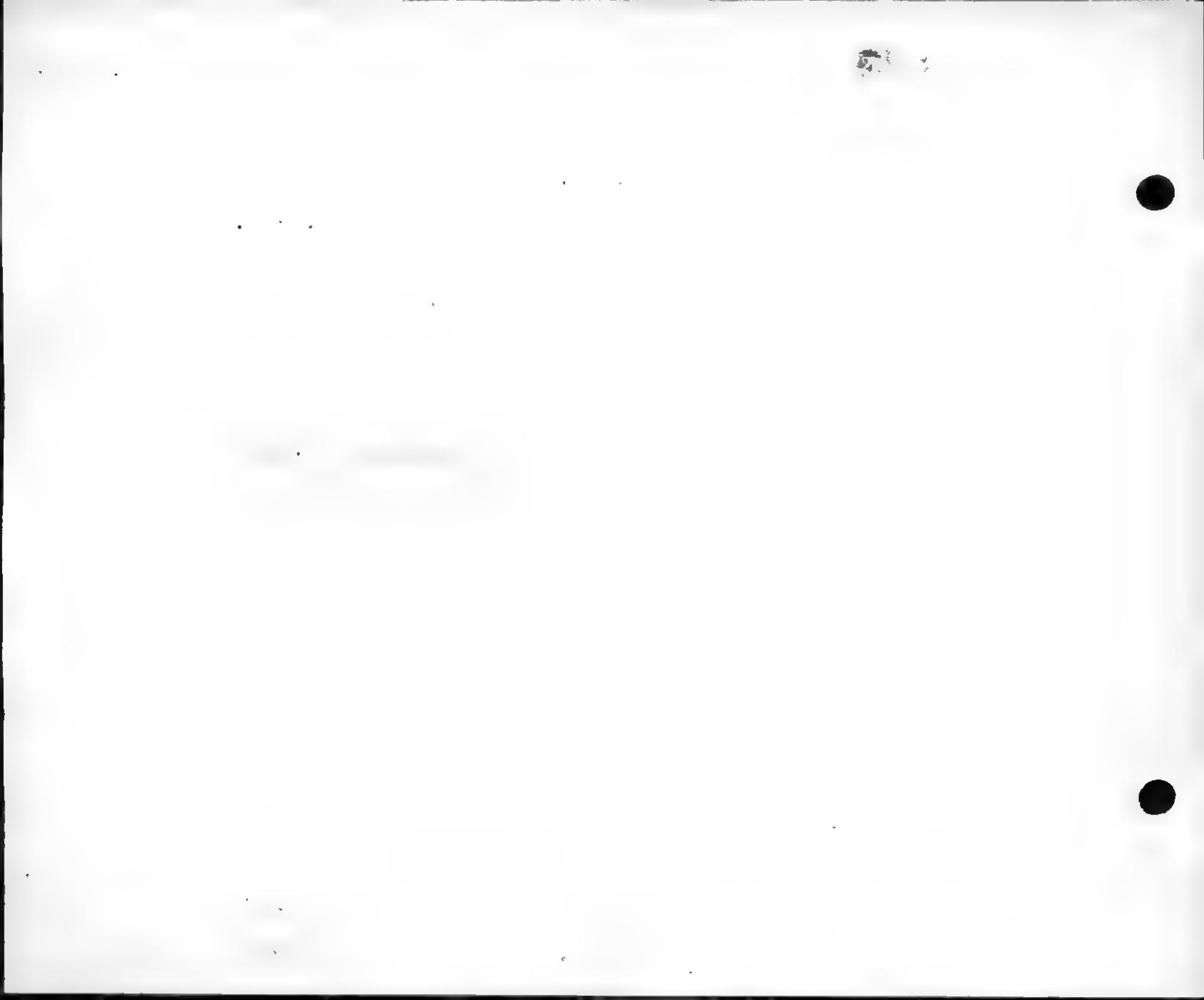
08397

08386

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil, in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

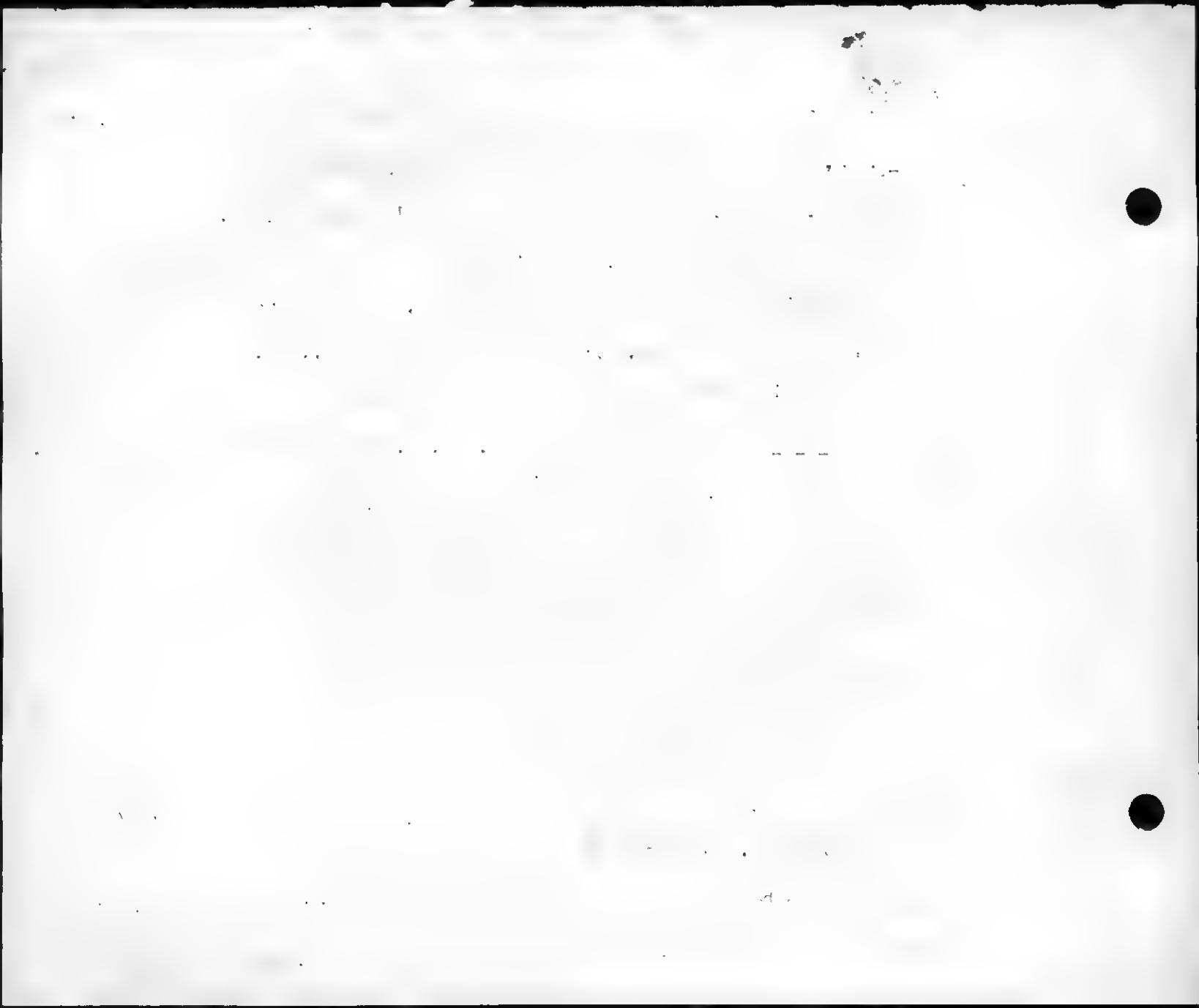
PLACE OF DEATH d COUNTY		Dorchester MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a STATE Maryland		b COUNTY Dorchester	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c LENGTH OF STAY IN 1b D.O.A.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d STREET ADDRESS Pine St. Ext.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)		First John	Middle Saunders	Lost	4 DATE OF DEATH June 5,	Month 1966	Day Year
S SEX Male	6 COLOR OR RACE Negro	7 MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6/10/95	9 AGE (In years last birthday) 70 yrs	10 UNDER 1 YEAR Months 0	11 UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Unknown				14 MOTHER'S MAIDEN NAME Unknown			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16 SOCIAL SECURITY NO W W I		17 INFORMANT Hagerfield Comb.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Emphysema, coronary sclerosis						INTERVAL BETWEEN ONSET AND DEATH Unknown	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)					
		DUE TO (c)					
PART II OTHER CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John Mace Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cambridge, Md.		22. DATE SIGNED 6/11/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-17-66		23c. NAME OF CEMETERY OR CREMATORIAL Bedford Cem.		23d. LOCATION (City or Town) (County) (State) Comt. Md.	
24 FUNERAL DIRECTOR Baker West		ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR DATE JUN 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												08398	08387				
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY Dorchester				MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				a. STATE Maryland b. COUNTY Dorchester					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Cambridge				c. LENGTH OF STAY IN 1b Life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Cambridge				d. STREET ADDRESS Airey's Road, RFD No. 2				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM H. SHENTON				First	Middle	Last	4. DATE OF DEATH June 1, 1966	Month	Day	Year							
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH March 6, 1894	9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed				10b. KIND OF BUSINESS OR INDUSTRY Blacksmith				11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md.				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Levin Shenton				14. MOTHER'S MAIDEN NAME Jane Mills													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Mrs. Wm. H. Shenton, RFD 2, Cambridge, Md.				Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gangrenous legs, bilateral</i> 4501 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Arterio - sclerotic arteritis</i> (c) <i>Arterio sclerosis, gen.</i>												2 mos 3-4 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from _____, 1966, to June 1, 1966 that (I) (we) last saw the deceased alive on June 1, 1966 and that death occurred at _____ M, from the causes and on the date stated above.												22b. DATE SIGNED 6/2/66					
22a. SIGNATURE <i>James U. Thompson, MD</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>				MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22c. PHYSICIAN'S NAME (Type) James U. Thompson, MD				22d. ADDRESS Locust St., Cambridge, Maryland													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Jun 4, 1966				23c. NAME OF CEMETERY OR CREMATORIUM East New Market Cemetery				23d. LOCATION (City, town or county) (State) East New Market, Maryland					
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland				ADDRESS				25a. REC'D BY REGISTRAR JUN 6 1966				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02399		08388	
1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE c. LENGTH OF STAY IN lb 4 WEEKS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON d. STREET ADDRESS	
3. NAME OF DECEASED First ANNE Middle C Last SHIPHERD (Type or print)		4. DATE OF DEATH Month JUNE Day 20 Year 1966	
5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/18/73 9. AGE (In years last birthday) 93 yrs 10. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
10c. CITIZEN OF WHAT COUNTRY? U.S.		11. BIRTHPLACE (County & State, or foreign country) MD.	
13. FATHER'S NAME George Seldon Cullum		14. MOTHER'S MAIDEN NAME Harriett Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16. SOCIAL SECURITY NO 220-46-9949 17. INFORMANT HOSPITAL RECORDS Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 466X MULTIPLE PULMONARY INFARCTS WITH INFARCT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO PNEUMONIA (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) EASTON (County) TALBOT (State)			
21. I certify that (I) (this hospital) attended the deceased from 5/27 , 1966 , to 6/20 , 1966 , that (I) (we) last saw the deceased alive on 5/20 , 1966 , and that death occurred at 6:40M , from causes and on the date stated above.			
22a. SIGNATURE Peter W. Rieckart M.D.		22b. DATE SIGNED 6/21/66	
22c. PHYSICIAN'S NAME (Type) Peter W. Rieckart		22d. ADDRESS E-Near Market, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) 6-22-66		23b. DATE THEREOF 6-22-66 Arriving Here 23c. NAME OF CEMETERY OR CREMATORIUM ADDRESS EASTON	
24. FUNERAL DIRECTOR W. G. Gask		25a. RECD BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE DATE JUN 23 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, please remove carbon papers. **Then**, if you are a funeral director, page 3 should be detached for use as the burial-transit permit. **Then**, please remove carbon papers. **Finally**, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.



1 M
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

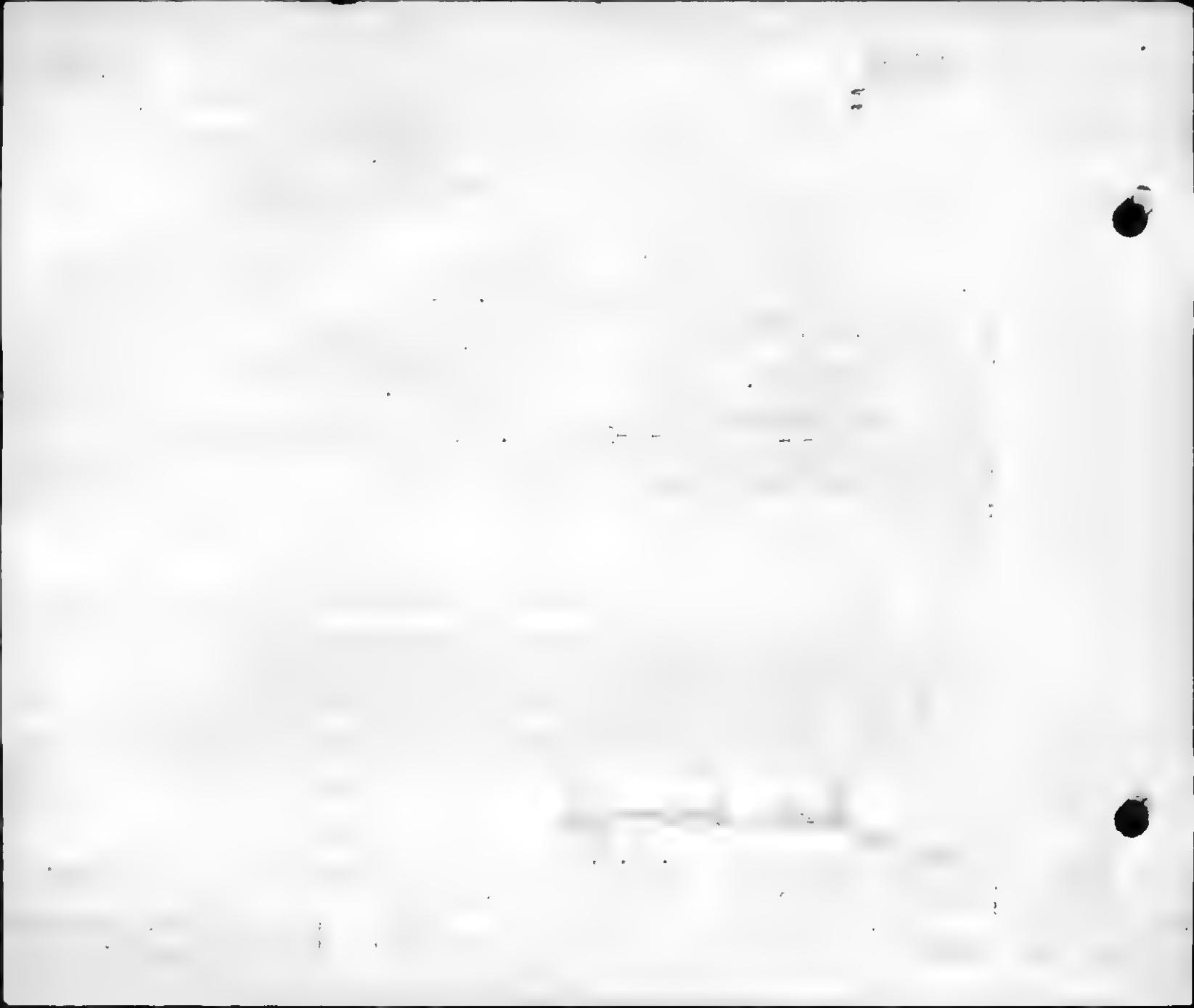
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08400

08389

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		b. COUNTY Dorchester	
c. LENGTH OF STAY IN 1b 40 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 412 Academy Street		d. STREET ADDRESS 412 Academy Street	
3. NAME OF DECEASED (Type or print) ALVERTA		First F.	Middle SMITH
4. DATE OF DEATH June 1, 1966	Month Day Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1903
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Roddvile, Maryland
13. FATHER'S NAME Lewis W. Meredith		14. MOTHER'S MAIDEN NAME Nora A. Hughes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO		16. SOCIAL SECURITY NO. 215-14-3246	17. INFORMANT Mrs. Wm. Brown, Federalsburg, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General carcinomatosis		Address ? ?	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) } DUE TO } (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Mace Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 6/2/66 Cambridge, Md.	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jun 3, 1966	22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Memorial Park	22d. LOCATION (City, town, or county) (State) Cambridge, Maryland
23. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS JUN 6 1966 DATE	REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

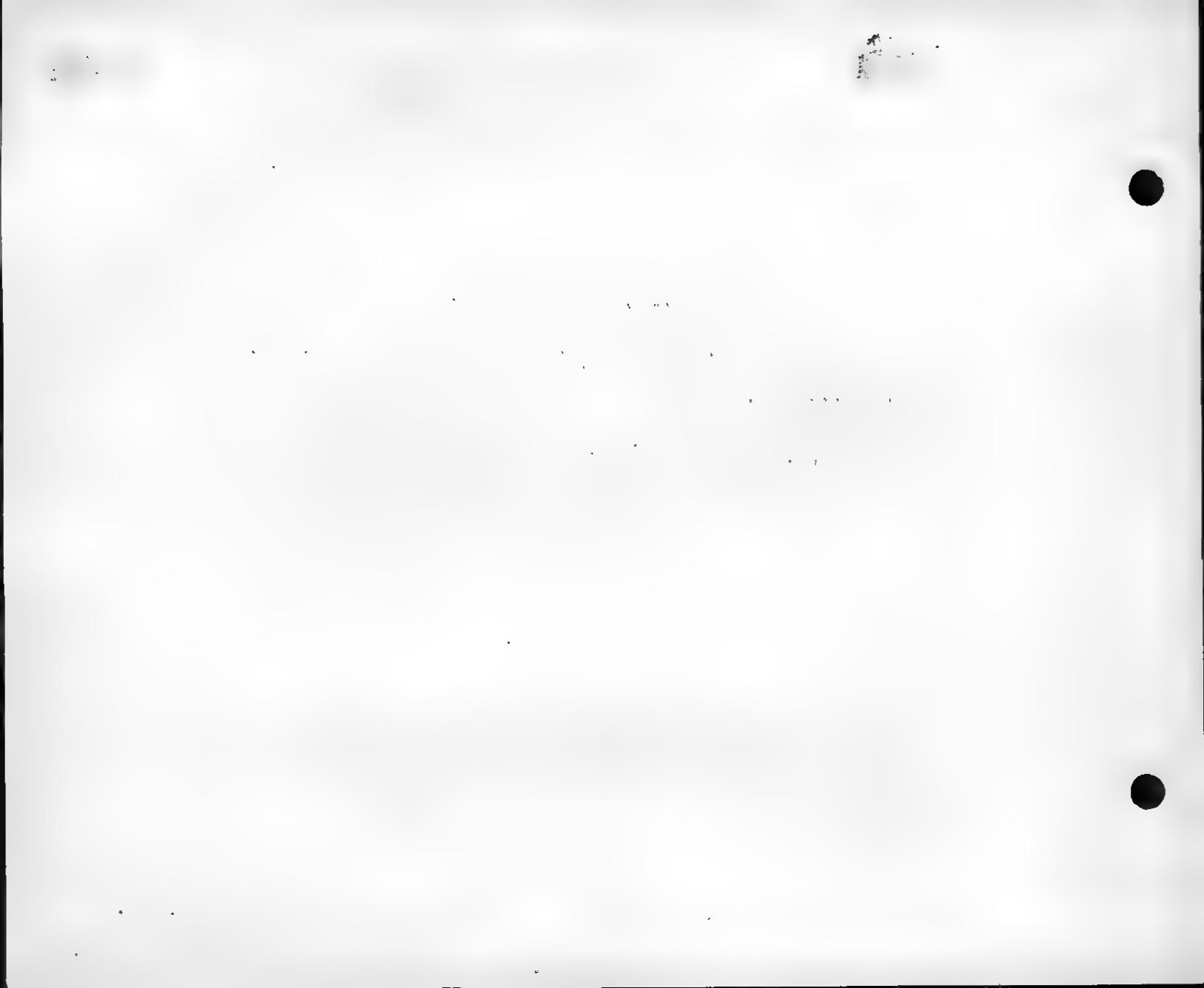
CERTIFICATE OF DEATH

08391

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 19 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSP.		d. STREET ADDRESS MATTIE MERRICK Nsyq. Home	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elston Hudson STEWART		4. DATE OF DEATH Month 6	Day Year 26 1966
5. SEX M	6. COLOR OR RACE W	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/1893 1941
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Ret.		10b. KIND OF BUSINESS OR INDUSTRY WIRKIN	11. BIRTHPLACE (County & State, or foreign country) Church Creek Dor. County MARYLAND
13. FATHER'S NAME Arthur T. Stewart		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes, W. War 1		16. SOCIAL SECURITY NO 215 18-4617	17. INFORMANT EASTERN SHORE STATE HOSP.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 6000 <i>Chronic</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyronephritis		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I(a) Cerebral vascular accident			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 102 a.m.
20f. (City or town) 102 a.m.		(County) (State) 102 a.m.	
21. I certify that (I) (this hospital) attended the deceased from 06-01- 1966 to 06-26, 1966 , that (I) (we) last saw the deceased alive on 06-26 1966 , and that death occurred at 102 a.m. from causes and on the date stated above.			
22a. SIGNATURE James F. Smith		22b. DATE SIGNED 26 June 1966	
22c. PHYSICIAN'S NAME (Type) James F. Smith		22d. ADDRESS EASTERN SHORE STATE HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 28, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Old Trinity Churchyard	23d. LOCATION (City or Town) Church Creek, Md.
24. FUNERAL DIRECTOR James F. Smith		25a. ADDRESS 102 a.m.	25b. REC'D BY REGISTRAR Charles Judge
		25c. DATE JUN 29 1966	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												118392		
CERTIFICATE OF DEATH														
1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)											
a. COUNTY Dorchester			a. STATE Maryland			b. COUNTY Dorchester								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN 1b 10 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital			d. STREET ADDRESS 400 Muse Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First NETHA Middle MOORE Last THOMAS			4. DATE OF DEATH June 25, 1966											
5. SEX Female			6. COLOR OR RACE White			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Nov. 23, 1900			9. AGE (In years last birthday) 65 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home			11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland			12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John T. Moore			14. MOTHER'S MAIDEN NAME Nancy Todd											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Mrs. Emma Arnie, Cambridge, Maryland			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												INTERVAL BETWEEN ONSET AND DEATH 14 hours		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cerebral hemorrhage									Undet.		
3810 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO (b) Cirrhosis of liver											
DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 6/23/66, 19, to 6/25, 1966, that (I) last saw the deceased alive on 6/25, 1966, and that death occurred at 6:00 P.M. from the causes and on the date stated above.														
22a. SIGNATURE Alfred Maryanov												22b. DATE SIGNED 6/27/66		
22c. PHYSICIAN'S NAME (Type) Alfred Maryanov, MD			22d. ADDRESS Race St., Cambridge, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF June 28, 1966			23c. NAME OF CEMETERY OR CREMATORIUM Dorchester Memorial Park			23d. LOCATION (City, town or county) Cambridge			(State) Maryland		
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
DATE JUN 29 1966														

Corporate partners
Corporate of year

6153150
6006

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

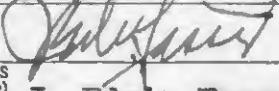
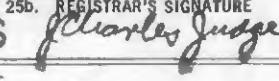
CERTIFICATE OF DEATH

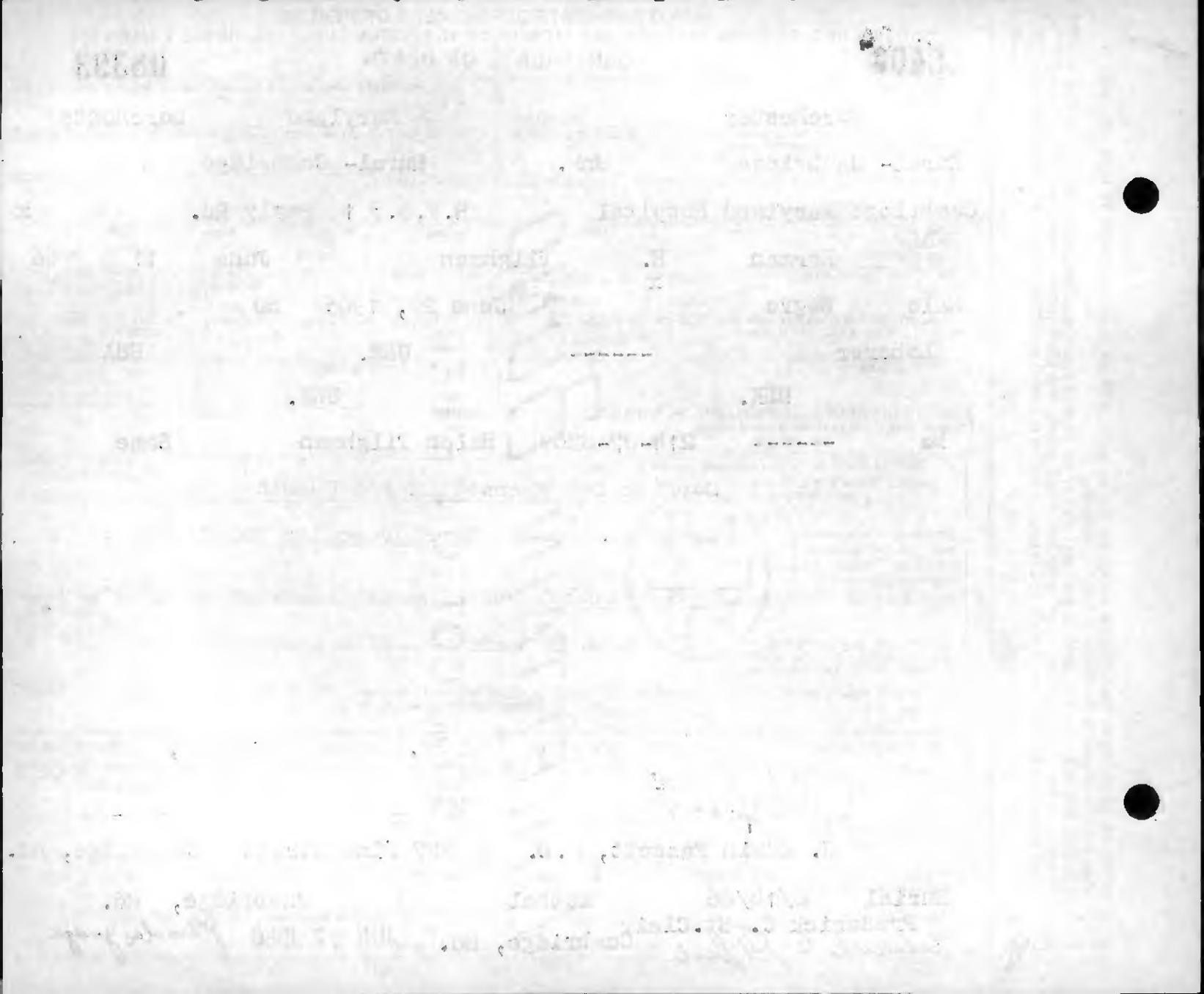
08403

08393

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

2 Page 4 may be retained by the hospital or attending physician.
 3 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
Dorchester MARYLAND		Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural- Cambridge		c. LENGTH OF STAY IN 1b Unk.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital		d. STREET ADDRESS R.F.D. # 1 Bayly Rd.	
3. NAME OF DECEASED (Type or print) Herman H. Tilghman		4. DATE OF DEATH June 11 1966	
5. SEX Male Negro		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		8. DATE OF BIRTH June 20, 1905	
10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) 60 yrs.	
11. BIRTHPLACE (County & State, or foreign country) UNK.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNK.		14. MOTHER'S MAIDEN NAME UNK.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-8269 17. INFORMANT Helen Tilghman Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).1 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 448X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Renal Disease		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 19, 1966 to June 11, 1966 that (I) (we) last saw the deceased alive on June 11, 1966 and that death occurred at M, from the causes and on the date stated above.		22b. DATE SIGNED 6-11-66	
22a. SIGNATURE 		22b. DATE SIGNED 6-11-66	
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.		22d. ADDRESS 727 Pine Street Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/14/66 23c. NAME OF CEMETERY OR CREMATORIAL Bethel	
24. FUNERAL DIRECTOR Frederick C. St. Clair		23d. LOCATION (City, town or county) (State) Cambridge, Md.	
ADDRESS 		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE JUN 27 1966 	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08404

CERTIFICATE OF DEATH

08394

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
Dorchester MARYLAND		Maryland Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pages 1 and 2 Cambridge		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 723 Hughlett St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Helen	Middle Jones	Last Todd
4. DATE OF DEATH	Month June	Day 14	Year 1966
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/1890
9. AGE (In years last birthday) 76 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Dorchester, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.	13. FATHER'S NAME W. F. Jones		
14. MOTHER'S MAIDEN NAME Cornelia -----		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 217-10-8696		17. INFORMANT Mrs. H. T. Slaughter	Address Easton, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 448 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia (c) Arterio sclerotic cardio vascular renal disease 1 year +			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
INTERVAL BETWEEN ONSET AND DEATH 1 week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Baltimore		(County) (State) Baltimore	
21. I certify that (I) (was hospitalized attended the deceased from 2-19-1966 p.m. 6-14-1966, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 6-14-1966, and that death occurred at 9:30M, from the causes and on the date stated above.			
22a. SIGNATURE Eldridge H. Wolff			
22b. DATE SIGNED 6-14-66			
22c. PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M. D.		22d. ADDRESS 615 Locust Street, Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/17/66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS E. New Market Cemetery Cambridge Md.		23d. LOCATION (City, town or county) (State) E. New Market Md.	
24. FUNERAL DIRECTOR Kenneth Shores Jr.		25a. REC'D BY REGISTRAR DATE JUN 20 1966	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

